PRO ADJUSTER CHIROPRACTIC CLINIC

NEW PATIENT IN TAKE

STEP ONE:

Welcome to our Practice.

STEP TWO:

All New Arrivals fill out this personal health history questionnaire.

STEP THREE:

A tour of our Facility.

STEP FOUR:

A one-on-one Education on how to improve YOUR health and well-being.

STEP FIVE:

A one-on-one conversation with our Doctor of Chiropractic.

STEP SIX:

A special Media Presentation about the Pro-Solution.

STEP SEVEN:

A report will be given to you about how your health can improve.

Confidential Patient Health Record **DATE:**_____

PERSONAL HISTORY

Name:_____ Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: Male or Female

Social Security #: _____

Social Insurance #:_____ E-Mail Address: _____

Business Employer:_____ Type of Work:_____

Business Phone:_____

Name of Spouse: _____ Spouse's Social Security #:_____

Spouse's Employer: _____ Business Phone: _____

Type of Work: _____ Name and Ages of Children: _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who is Responsible for Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐Personal Health Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name _____ Date of Birth: _____

CURRENT HEALTH CONDITION

Unwanted Health Condition: _____

Other Doctors Seen for this Conditions: ☐ YES ☐ NO Who? _____

Type of Treatment: _____ Results: _____

When did this Conditions Begin? _____ Has this Condition Occurred Before? ☐ YES ☐ NO

Is Conditions: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made a Report of Your Accident to Your Employer: ☐ YES ☐ NO

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other: _____

Do You Wear A Shoe Lift? ☐ YES ☐ NO

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?_____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐Broken Bones ☐Other: _____

Major Accidents or Falls: _____

Hospitalization (Other than Above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.
CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Tuberculosis
☐ Whooping Cough ☐ Cancer
☐Anemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox
☐ Diabetes
☐Mental Disorders
☐ Heart Disease
☐ Thyroid
☐ Influenza
☐ Pleurisy
☐ Arthritis
☐ Epilepsy
☐ Cigarettes
☐ Lumbago
☐ Eczema

INTAKE
☐ Coffee
☐ Tea
☐Alcohol
☐ White Sugar

Have you been tested HIV positive? ☐ YES ☐ No

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.
REVIEW OF SYSTEMS- Please fill out all of the sections, even if "DENY"

Constitutional: I…. □ Deny Any Constitutional Issue (s)

□ Chills
□ Weight Gain
□ Daytime Somnolence (Drowsiness)
□ Weight Loss
□ Fatigue
□ Fever
□ Night Sweats

Eyes/Vision: I…. □ Deny Any Eyes/Vision Issue (s)

□ Blindness
□ Eye Pain
□ Tearing
□ Cataracts
□ Change in Vision
□ Double Vision
□ Blurred Vision
□ Field Cuts (visual field defect)
□ Wears Glasses/Contact Lenses
□ Glaucoma
□ Itching (around eyes)
□ Photophobia

Ears,Nose & Throat: I…. □ Deny Any Ears, Nose & Throat Issue (s)

□ Bleeding
□ Headaches
□ Snoring
□ Ear Drainage
□ Nose Bleeds (frequent)
□ Dentures
□ Hearing Loss
□ Tinnitus (Ringing in Ears)
□ Ear Pain
□ Dizziness
□ Nasal Congestion
□ Dental Implants
□ Head Injury
□ Ear Infections
□ Post Nasal Drip
□ Sinus Infections
□ TMJ Problems
□ Fainting
□ Loss of Smell
□ Sore Throats (frequent)
□ Discharge
□ Rhinorrhea (Runny Nose)
□ Difficulty Swallowing
□ Hoarseness

Respiration: I…. □ Deny Any Respiration Issue (s)

□ Asthma
□ Coughing Up Blood
□ Sputum Production
□ Cough
□ Shortness of Breath
□ Wheezing

Gastrointestinal: I…. □ Deny Any Gastrointestinal Issue (s)

□ Abdominal Pain
□ Nausea
□ Belching
□ Rectal Bleeding
□ Hemorrhoids
□ Constipation
□ Vomiting Blood
□ Jaundice (Yellowing Skin)
□ Difficulty Swallowing
□ Abnormal Stool
□ Heartburn
□ Black, Tarry Stool
□ Vomiting
□ Indigestion
□ Diarrhea
□ Abnormal Stool Color

Endocrine: I…. □ Deny Any Endocrine Issue (s)

□ Cold Intolerance
□ Voice Changes
□ Goiter
□ Hair Loss
□ Heat Intolerance
□ Unusual Hair Growth
□ Frequent Urination
□ Diabetes
□ Excessive Appetite
□ Excessive Hunger
□ Excessive Thirst

Nervous System: I…. □ Deny Any Nervous System Issue (s)

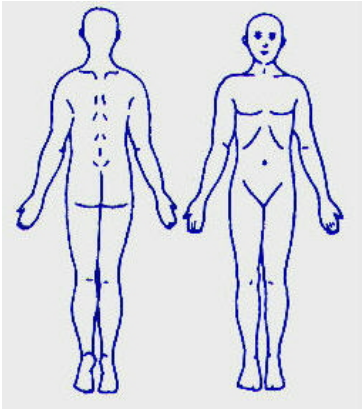
□ Dizziness
□ Facial Weakness
□ Headaches
□ Limb Weakness
□ Loss of Consciousness
□ Loss of Memory
□ Numbness
□ Seizures
□ Sleep Disturbances
□ Stress
□ Strokes
□ Tremors
□ Unsteadiness of Gait
□ Slurred Speech

Allergy: I…. □ Deny Any Allergy System Issue (s)

□ Anaphylaxis (history of)
□ Itching
□ Nasal Congestion
□ Food Intolerance
□ Sneezing

Please outline on the diagram the area of your discomfort

A= Aches B=Burning N=Numbness
P= Pins & Needles S= Stabbing O= Other



Cardiovascular: I…. □ Deny Any Cardiovascular Issue (s)

□ Angina (Chest Pain)
□ Claudication (Leg Pain)
□ Heart Problems
□ Orthopnea (difficulty breathing while lying down)
□ Palpitations (irregular or forceful beating of heart)
□ Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath)
□ Shortness of Breath with Exertion or Exercise
□ Ulcers
□ Heart Problems
□ Heart Murmur
□ Swelling of Legs
□ Varicose Veins

Female: I…. □ Deny Any Female Issue (s)

□ Birth Control Therapy
□ Burning Urination
□ Frequent Urination
□ Irregular Menstruation
□ Vaginal Bleeding
□ Breast Lumps/Pain
□ Cramps
□ Hormone Therapy
□ Urine Retention
□ Vaginal Discharge

Are you pregnant? Yes/No Date of Last Period:_____

Male: I…. □ Deny Any Male Issue (s)

□ Burning Urination
□ Prostate Problems
□ Frequent Urination
□ Erectile Dysfuncti
□ Urine Retention
□ Hesitancy/Dribbling

Skin: I…. □ Deny Any Skin Issue (s)

□ Changes in Nail Texture
□ Hair Growth
□ Itching
□ Rash
□ Skin Lesions/Ulcers
□ Hair Loss
□ Paresthesia (numbness, prickling or tingling)
□ History of Skin Disorder
□ Changes in Skin Color
□ Hives
□ Varicositites

Psychologic: I…. □ Deny Any Psychologic Issue (s)

□ Anhedonia
□ Confusion
□ Depression
□ Behavioral Changes
□ Bipolar Disorder
□ Convulsions
□ Appetite Changes
□ Mood Changes
□ Anxiety
□ Insomnia
□ Memory Loss

Hematology: I…. □ Deny Any Hematology Issue (s)

□ Anemia
□ Blood Transfusion
□ Lymph Node Swelling
□ Bleeding
□ Bruises Easy
□ Blood Clotting
□ Fatigue

DO NOT WRITE BELOW THIS LINE

ANAYLSIS:
DIAGNOSIS:
Patient Accepted: □ YES □ NO □ Referred

_____
Doctor's Signature

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ **Relief Care** ☐ **Corrective Care** ☐ **Check here if you want the Doctor to select the type of care appropriate for your condition**

_____ _____

Date Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You !

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature_____ **Date:**_____

Consent to treat a Minor _____ **Date:**_____

Guardian or Spouse's Signature of Authorizing Care:_____ **Date:** _____