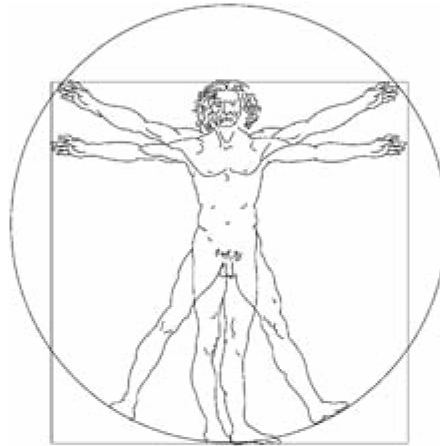
# TO THE NEW PATIENT



## Outline of Procedure for New Patients

1. STEP ONE: All new patients are requested to fill out a personal health history questionnaire.

2. STEP TWO: Your first consultation with a doctor to discuss your health problems.

3. STEP THREE: Diagnostic chiropractic, orthopedic & neurological examination procedures to determine if chiropractic care is appropriate for your condition.

4. STEP FOUR: The Doctor will advise you as to the need of additional procedures such as laboratory & X-ray tests, if necessary.

5. STEP FIVE: If your case requires immediate attention, emergency first aid will be administered.

6. STEP SIX: You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

7. STEP SEVEN: After you return and receive your report of findings your recommended treatment program will be explained to you.

8. STEP EIGHT: Treatments will begin and continue as scheduled until your condition has been fully corrected or until the maximum possible improvement has been obtained.

# PATIENT INFORMATION FORM

☐ New Patient ☐ New Case ☐ Change Only

First name: ______________________ Middle: __________ Last: ___________________________

Address: ____________________________ City ___________ State _____ Zip Code ___________

Home phone#: __________________ Work #: ___________________ Cell#: ___________________

Your social security number: __________ ________ ____________

Your birthdate: ______ _____ ____________ ☐ Male ☐ Female

Your Employer: ___________________________________________________________________

Is insurance through your employer? ______________________________________________

**Type of Insurance:**

☐ I don't have insurance, I will be paying cash.

☐ I have an HMO that doesn't cover this type of care.

Who is the primary insured? Name: ______________________________________

Relationship to you ☐ My spouse ☐ Parent ☐ Other __________________________

Primary insured's social security number: ________________________________

Primary's date of birth: _____/______/_________

Is this insurance through a company or an individual private policy? _________________________

If it is through a company, what is the name of the company? _____________________________

Accident related? ☐ Yes ☐ No Accident State ___________________

Work related? ☐ Yes ☐ No Employer where injured:

**ABOUT YOUR INSURANCE:**

☐ I don't have any insurance.

☐ I have a network HMO insurance that doesn't cover this type of care.

| PRIMARY INSURANCE INFORMATION | SECONDARY INSURANCE INFORMATION |
|---|---|
| Insurance Co.: ____________________<br>Address: ____________________<br>City/State/Zip ____________________<br>Phone: ____________________<br><br>Member ID # ____________________<br>Group # ____________________<br>Primary insured person: ______________<br>Relationship to me: ______________ | Insurance Co.: ____________________<br>Address: ____________________<br>City/State/Zip ____________________<br>Phone: ____________________<br><br>Member ID # ____________________<br>Group # ____________________<br>Secondary insured person: ______________<br>Relationship to me: ______________ |

## FOR OFFICE USE ONLY

| | | | | |
|---|---|---|---|---|
| Diagnosis | 1) | | - | |
| Diagnosis | 2) | | - | |
| Diagnosis | 3) | | - | |
| Diagnosis | 4) | | - | |

MEDICARE ONLY:

| | | | | | | |
|---|---|---|---|---|---|---|
| X-Ray Date | | | | | Area of Subluxation | |
| Referring Physician | | | | | | |

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ❑ Appendicitis
- ❑ Alcoholism
- ❑ Anemia
- ❑ Arthritis
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Eczema
- ❑ Epilepsy
- ❑ Goiter
- ❑ Heart Disease
- ❑ Influenza
- ❑ Lumbago
- ❑ Malaria
- ❑ Measles
- ❑ Mental Disorder
- ❑ Mumps
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Small Pox
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Venereal Infection
- ❑ Whooping Cough

CHECK ANY YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

**MUSCULO-SKELETAL CODE**

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult Chewing/Clicking Jaw

❑ **NERVOUS SYSTEM CODE**

- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depressions
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Excessive thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Gall Bladder Problems
- ❑

❑ **GENERAL CODE**

- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

**GENITO-URINARY CODE**

- ❑ Bladder Trouble
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

**C-V-R CODE**

- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling

**GASTRO-INTESTINAL CODE**

- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Gall Bladder Problems
- ❑ Liver Trouble
- ❑ Weight Trouble
- ❑ Gas/Bloating After Meals
- ❑ Abdominal Cramps
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

**EENT CODE**

- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose
- ❑ Sore Throat

**MALE/FEMALE CODE**

- ❑ Menstrual Irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal Pain/Infections
- ❑ Breast Pain/Lumps
- ❑ Prostate/Sexual Dysfunction

**FEMALES ONLY**

When was your last period? ______________

Are you pregnant? Yes No

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go 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). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your Doctor consider your needs and desires when recommending your treatment program.

Please check the type of care you desire so that we may be guided by your wishes whenever possible.

❑ Relief Care ❑ Corrective Care ❑ Comprehensive Care

❑Check here if you want the Doctor to select the type of care appropriate for your condition.

_______/________/_________ X ______________________________________________

Date Patient's Signature

If this is an accident related injury, please fill out the Accident Questionnaire next.

**THE PURPOSE OF OUR CHIROPRACTIC CENTER**

**IS TO SUPPORT EACH INDIVIDUAL**

**IN ACHIEVING THEIR OPTIMUM HEALTH**

**AND TO**

**EDUCATE THEM SO THAT THEY MAY**

**UNDERSTAND HEALTH, AND CHIROPRACTIC,**

**AND IN TURN EDUCATE OTHERS.**

I understand and agree that health and accident insurance policies are an arrangement between and 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 on 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature X____________________________________________SS#_______-_____-________Date_____/______/_______

Guardian or Spouse's
Signature Authorizing Care_________________________________________________________________Date_____/______/_______