

# 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:**

Chiropractic examination and Orthopedic and Neurological examinations are related to chiropractic to determine chiropractic care for you.

### **4. STEP FOUR:**

The doctor will advise you as to the need of additional procedures such as x-ray tests, if necessary.

### **5. STEP FIVE:**

You will be given a "**Report of Findings**" on your second scheduled visit. The doctor will inform you as to your examination results. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

### **6. STEP SIX:**

After you receive your report of findings, your recommended course of care will be explained to you.

### **7. STEP SEVEN:**

Adjustments will begin and continue as scheduled until maximum correction for you has been obtained.

### **8. STEP EIGHT:**

After maximum correction, a schedule of care will be recommended.

# PERSONAL HISTORY

Date: \_\_\_\_\_ E-mail \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Business/Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
Check One  Married  Single  Widowed  Divorced  Separated No. Of Children: \_\_\_\_\_  
Patient's SS# \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Spouse's SS# \_\_\_\_\_  
Primary Care Provider Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Referred to this office by: \_\_\_\_\_  
Who is Responsible for your Bill, You and:  Spouse  Workman's Compensation  Medicare  
 Auto Insurance  Personal Health Insurance  Other \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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## CURRENT HEALTH CONDITION

Purpose of This Appointment: \_\_\_\_\_  
Major Complaint: \_\_\_\_\_  
Other Doctor's Seen For This Condition: \_\_\_\_\_  
When Did This Condition Begin: \_\_\_\_\_  
Are There Others In Your Family With This Same Condition: \_\_\_\_\_  
\_\_\_\_\_  
If Disabled From Work Please Give Dates: \_\_\_\_\_  
 Job Related  Auto Related  Date of Accident/Injury \_\_\_\_\_  
Medication You Now Take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure  
 Insulin  Aspirin/Similar  Other \_\_\_\_\_

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## PAST HEALTH HISTORY

Please Check or Describe:

Major Surgery/Operations:  Appendix  Tonsils  Gall Bladder  Hernia  Heart  Back  
 Neck  Leg  Other \_\_\_\_\_  
Major Accidents or Falls: \_\_\_\_\_  
\_\_\_\_\_  
Hospitalization (Other Than Above): \_\_\_\_\_  
\_\_\_\_\_  
Previous Chiropractic Care: Doctor's Name and Approximate Date of Last Visit: \_\_\_\_\_  
\_\_\_\_\_  
Have You Been Treated For Any Health Condition In The Last Year?  Yes  No  
If Yes, Please Explain: \_\_\_\_\_  
Does Anyone Else In Your Family Have The Same Or Similar Condition? \_\_\_\_\_

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 chiropractic care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza       |
| <input type="checkbox"/> Rheumatic Fevër | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy        |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis       |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy        |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago         |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema          |

**INTAKE**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar
- Soft Drinks/Coke, Pepsi, Dr. Pepper, etc.

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:**

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_

Are you Pregnant?

- Yes     No     Not Sure

**MUSCULO-SKELETAL CODE**

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

- Gas/Bloating after Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**GENITO-URINARY CODE**

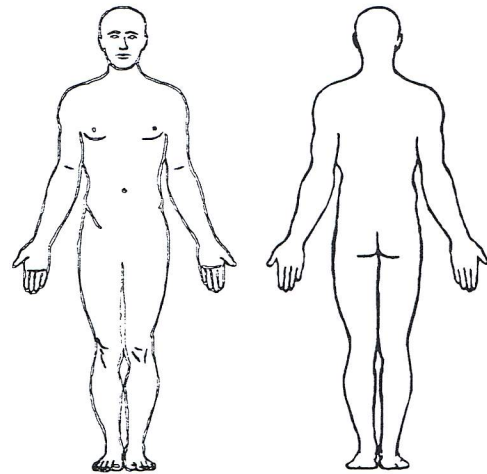
- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**NERVOUS SYSTEM CODE**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**C-V-R CODE**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke



Please outline on the diagram the area of your discomfort.

**GENERAL CODE**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**EENT CODE**

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

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**MALE/FEMALE CODE**

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

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

\_\_\_\_\_  
Doctor's Signature

