



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 #: _____

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 _____

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? _____

