HAMPDEN COUNTY CHIROPRACTIC

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 the doctor to discuss your health problems.

3. **STEP THREE**: Diagnostic chiropractic, orthopedic, and 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 and 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.

PERSONAL HISTORY

Date: _____ Social Security #: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Birthdate: _____ Age: _____ Sex: M F

Business/Employer: _____ Type of Work: _____

Circle One: Married Single Widowed Divorced Separated # Of Children _____

Name And # Of Emergency Contact: _____

Referred To This Office By: _____

Who Is Responsible For Your Bill: ( ) Self ( ) Spouse ( ) Workman's Comp.

( ) Medicaid ( ) Medicare ( ) Auto Insurance ( ) Major Medical Insurance

( ) Other _____

CURRENT HEALTH CONDITION

Purpose Of This Appointment: _____

_____

Other Doctors Seen For This Condition: _____

When Did This Condition Begin: _____

( ) Job related ( ) Auto related

Drugs You Now Take: ( ) Nerve Pills ( ) Pain Killers/Muscle Relaxers

( ) Blood Pressure Medicine ( ) Insulin ( ) Other:

PAST HEALTH HISTORY

Please Check Or Describe:

Major Surgery/Operations: ( ) Appendectomy ( ) Tonsillectomy ( ) Gall Bladder

( ) Hernia ( ) Broken Bones: ( ) Other: _____

Major Accidents Or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ( ) None ( ) Doctor's Name & Approx. Date Of Last Visit: _____

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 effect your overall diagnosis, treatment plan, and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

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

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

MUSCULO-SKELETAL

___ Low Back Pain
___ Pain Between Shoulders
___ Neck Pain
___ Arm Pain
___ Joint Pain/Stiffness
___ Walking Problems
___ Difficult Chewing/Clicking jaw

NERVOUS SYSTEM

___ Numbness
___ Paralysis
___ Dizziness
___ Forgetfulness
___ Confusion/Depression
___ Fainting
___ Convulsions
___ Cold/Tingling Extremities

GASTRO-INTESTINAL

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

GENITO-URINARY

___ Bladder Trouble
___ Painful/Excessive Urination
___ Discolored Urine

CARDIO-RESPIRATORY

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

EENT

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

MALE/FEMALE

___ Prostate/Sexual Dysfunction
___ Menstrual Irregularity
___ Menstrual Cramping
___ Last Menstrual Period
___ Are you pregnant
___ Vaginal Pain/Infections
___ Breast Pain/Lumps

GENERAL

___ Allergies
___ Loss of Sleep
___ Headache
___ Fever

Is this a stressful period in your life?

___ Yes ___ No

What do you consider stressful?

_____

_____

_____

_____

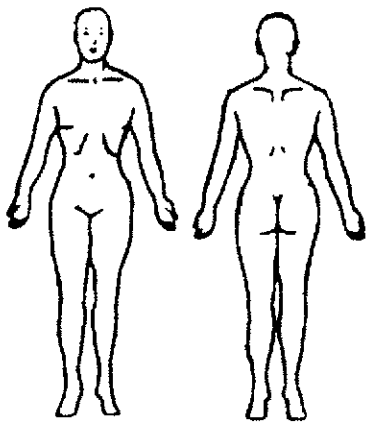
ANYTHING ELSE NOT COVERED?

_____

_____

_____

Please Draw in Painful Area(s) below.



DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient Accepted: ___ Yes ___ No

_____
Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Temporary Relief). 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 will weigh your needs and desires when recommending your Chiropractic Care program.

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

☐Temporary relief ☐Corrective care

☐Comprehensive Care ☐I prefer the doctor select the type of care he/she feels is best for me.

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? ☐Yes ☐No

Do you have Health Insurance? ☐Yes ☐No If yes, Policy # _____

Name of Company _____ Agent's Name _____

Are you covered by Medicare? ☐Yes ☐No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic 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: _____ Date _____

Guardian or Spouse's Signature _____

Doctor's Signature _____

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better understanding of your total health picture.

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

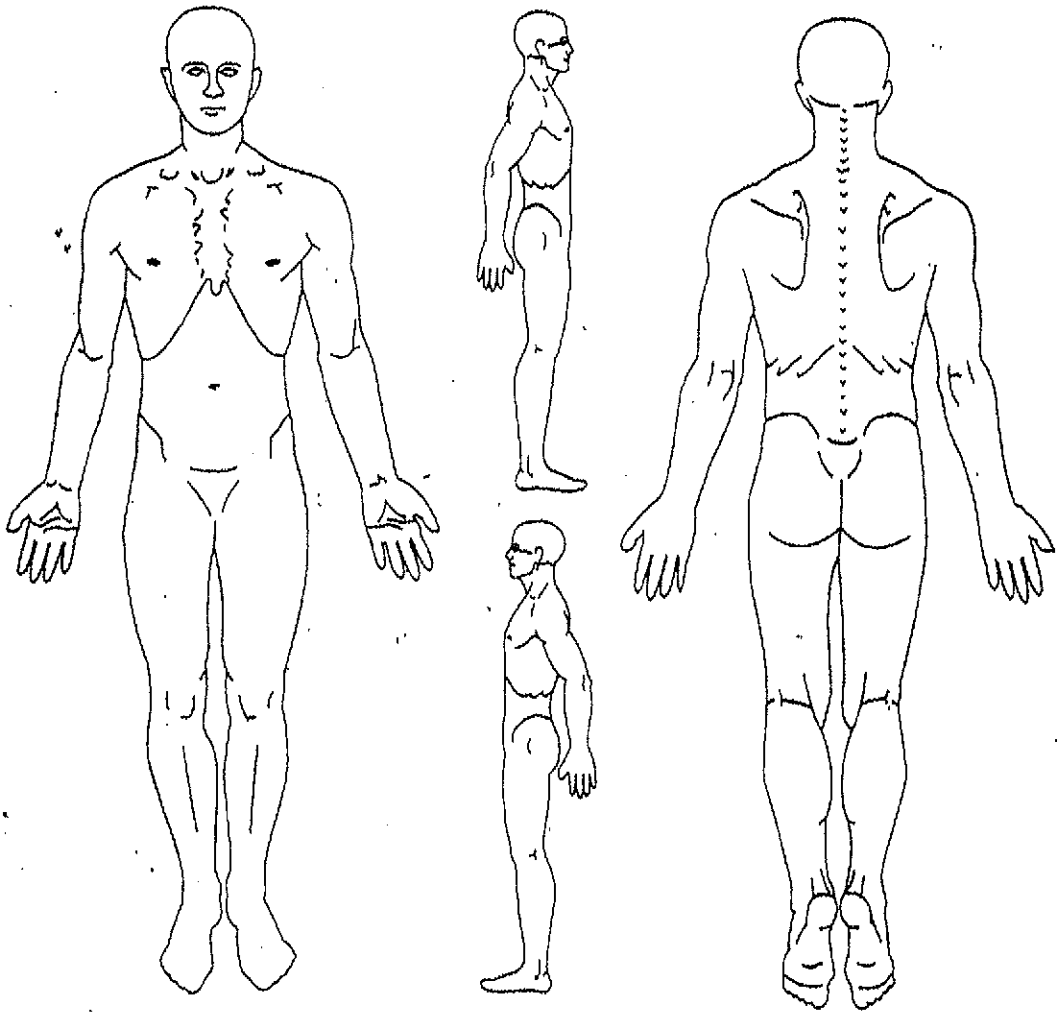
The purpose of
HAMPDEN COUNTY CHIROPRACTIC
is to support individuals
in achieving their optimum health
and to
educate them so that they may
understand health
and Chiropractic
and in turn
educate others.

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week

No Pain — Unbearab

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearab