WELCOME TO THE CHIROPRACTIC CONNECTION

"At The Chiropractic Connection you will be treated with compassion and concern in a warm caring atmosphere"

PROCEDURE OUTLINE FOR NEW PATIENTS

1. All new patients are requested to sign in, fill out a health history questionnaire, pain chart and a financial form.
2. Your consultation with the doctor will be used to discuss your health problem
3. The doctor will perform chiropractic, orthopedic, neurologic and postural examinations to determine if chiropractic care is appropriate for your condition.
4. The doctor will then advise you if additional procedures such as X-ray or lab tests are necessary.
5. If your case requires immediate attention, emergency care will be administered.
6. We will then set up an appointment that is convenient for you to return for your REPORT OF FINDINGS. At that time the doctor will go over your exam results, make recommendations for care and answer any questions regarding insurance or finances.
7. Treatment will begin and continue until your condition has been fully corrected or until maximum improvement has been reached.

PATIENT INFORMATION

NAME_____ DATE_____

HOME ADDRESS_____CITY_____STATE_____ZIP CODE_____

HOME PHONE_____WORK PHONE_____

MOBILE PHONE_____SOCIAL SECURITY#_____

DATE OF BIRTH_____AGE_____

OCCUPATION_____EMPLOYER_____

MARITAL STATUS_____SPOUSE"S NAME_____WORK PHONE_____

CHILDREN_____ WHO MAY WE THANK FOR REFERRING YOU TO US?_____

EMAIL ADDRESS:_____

If it is determined that Chiropractic care can be of benefit to you, and you accept care in this office, your method of payment will be: CASH_____ CHECK_____ CREDIT CARD_____ INSURANCE_____

INSURANCE INFORMATION (Please provide an insurance card so we may make a copy for your file)

INSURED'S NAME_____ID#_____

INSURANCE COMPANY_____GROUP#_____,

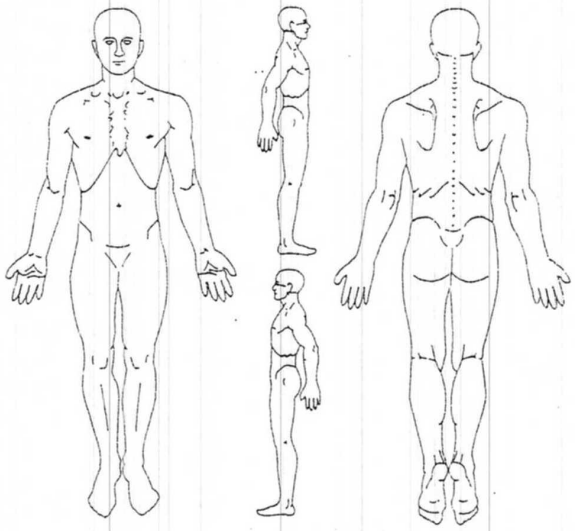
I do hereby authorize and request chiropractic services for myself, or my child/ward (if patient is a minor), and give my consent to any advisable and necessary procedures, laboratory, x-rays or physiotherapy to be administered by the attending physician or the physician's supervised staff for diagnostic purposes and treatment.

SIGNATURE_____DATE_____

PARENT OR GUARDIAN (If a minor)_____DATE_____

THE CHIROPRACTIC CONNECTION

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



MARK ON THE PICTURE WHERE YOU HAVE PAIN AND OTHER SYMPTOMS.

1. Please describe your complaint_____

_____

a. Description: ____sharp pain ____dull pain ____ache ____weak ____throbbing ____numb ____shooting ____gripping ____burning ____tingling
b. Frequency: ____constant(76-100%) ____frequent(51-75%) ____occasional(26-50%) ____intermittent(25% /less)
c. Indicate the intensity of your pain: **no pain 0 1 2 3 4 5 6 7 8 9 10 unbearable pain**
d. Your symptoms are: ____decreasing ____no change ____increasing
e. Symptoms are worse in the: ____morning ____afternoon ____night ____increases during day ____same all day

2. When did your problem begin?_____Describe_____

_____

3. Have you been treated for this injury? ____yes ____no
If yes. By whom ____Chiropractor ____M.D. ____Osteopath ____P/T ____O/T ____Other
Are you currently being treated? ____yes ____no When and what treatment did you receive_____

_____

4. In the past, have you been treated for a similar problem? ____yes ____no
If yes, by whom ____Chiropractor ____M.D. ____Osteopath ____P/T ____O/T ____Other
What type of treatment did you receive?_____

5. What makes your problem better? ____Nothing ____Lying down ____Walking ____Standing ____Sitting ____Inactivity ____Movement/Exercise
6. What makes it worse? ____Nothing ____Lying down ____Walking ____Standing ____Sitting ____Inactivity ____Movement/Exercise
7. How would you rate your stress level? ____Little ____Minimal ____Moderate ____Great stress
8. General physical activity. ____No regular exercise ____Light exercise ____Moderate exercise ____Strenuous

PATIENT NAME_____DATE_____

9. Are your complaints affecting your ability to be active? ____No effect ____Some physical restrictions
____Need assistance with common everyday tasks ____Need assistance often ____Need assistance to function
____Cannot care for self, disabled.

10. Physical activity at work ____Sit more than 50% ____Light labor ____Manual labor ____Heavy labor
____Repeated motion

11. Occupation_____ ___F/T ___P/T **Has work status changed due to pain?** __yes __no

12. What is your current work status? ____F/T no restrictions ____F/T with restrictions ____P/T no restrictions
____P/T with restrictions ____Off work ____Homemaker ____Unemployed ____Full time student

If you have ever had any of the listed conditions, please mark the past column. If you are currently troubled by a listed condition, please mark the present column. This will help the doctor evaluate your health care needs.

Past	Present		Past	Present		Past	Present	
___	___	Neck Pain	___	___	Aortic Aneurysm	___	___	High blood pressure
___	___	Shoulder pain	___	___	Angina	___	___	Heart attack
___	___	Pain in arm or elbow	___	___	Stroke	___	___	Asthma
___	___	Hand pain	___	___	Cancer	___	___	Tumor
___	___	Wrist pain	___	___	Prostate problems	___	___	Emphysema
___	___	Mid-back pain	___	___	Osteoarthritis	___	___	Rheumatoid arthritis
___	___	Low back pain	___	___	Diabetes	___	___	Ulcer
___	___	Upper leg or hip pain	___	___	Hepatitis	___	___	Colitis
___	___	Lower leg or knee pain	___	___	Irritable bowel syndrome	___	___	Fibromyalgia
___	___	Ankle or foot pain	___	___	HIV/AIDS	___	___	Jaw pain
___	___	Dizziness	___	___	Headache	___	___	Tinnitus
___	___	Rapid heart beat	___	___	Chest pains	___	___	Anorexia
___	___	Abnormal weight gain/loss	___	___	Chronic cough	___	___	Excessive thirst
___	___	General fatigue	___	___	Irregular menstrual flow	___	___	Profuse menstrual flow
___	___	Fibrocystic breast	___	___	Endometriosis	___	___	PMS
___	___	Painful urination	___	___	Frequent urination	___	___	Abdominal pain
___	___	Constipation	___	___	Heartburn / indigestion	___	___	Dermatitis/eczema/rash
___	___	Rash						

Does a family member have any of the following: ___Cancer ___Rheumatoid arthritis ___Diabetes
___Heart problems ___Lung problems ___High blood pressure ___Epilepsy ___Chronic back problems
___Chronic headaches ___Lupus ___Other conditions

Please check any of the following that apply to you: ___Pregnant ___Birth control pills ___Smoke
___Hormone replacement therapy ___Alcohol ___Coffee/Tea/Caffeinated soft drinks: Per day_____
___Drug or alcohol dependence ___Medications: Please list_____
___Hospitalizations: Please list_____

Please feel free to make any additional comments or address any issues that are not covered on this form !!

_____

_____

_____

Patient signature_____**Date**_____