Family
CHIROPRACTIC
CENTER

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, 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:** 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.

6. **STEP SIX:** After you return and receive your report of findings your recommended treatment program will be explained to you.

7. **STEP SEVEN:** 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

Driver's License No. _____

Date: _____ Social Security No.: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Birthdate: _____ Age: _____ Sex: M F

Employer & Address _____ Type of Work: _____

Name of Spouse _____ Spouse Birthdate _____
(First) (Middle) (Last)

Spouse Employer & Address _____ Business Phone _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated No. of Children _____

Name of Emergency Contact: _____ Phone No.: _____

Referred To This Office By: _____

Who is Responsible For Your Bill: ☐Self ☐ Spouse ☐ Workman's Comp.
☐Medicare ☐Auto Insurance ☐ Group Health Insurance ☐ Grp. No. _____ _____

CURRENT HEALTH CONDITION

Purpose of This Appointment: _____

Other Doctors Seen For This Condition: _____

When Did This Condition Begin: _____

If Disabled From Work Please Give Dates: _____

☐ 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:

- ☐ Appendicits
- ☐ 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
- ☐ Veneral Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING 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/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL CODE

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever

GASTRO-INTESTINAL CODE

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

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

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

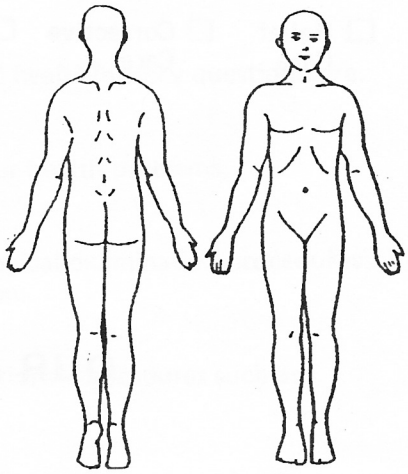
EENT CODE

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

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vagina' Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

Please ✔ on the diagram the area of your discomfort.



FEMALES ONLY:

When was your last period?_____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Signature_____

I understand and agree that health and accident insurance 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 collection 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 to 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 to me will be immediately due and payable. I also give this office power of attorney to endorse checks, made out to me, to be credited to my account.

Signature_____

(If patient is a minor, name of parent, guardian, etc.)

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 will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired 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.

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.

Family Chiropractic and Acupuncture Center
2801 Waterman Blvd Ste 260
Fairfield, CA 94534
(707) 427-1222

Privacy Issues Protected By HIPAA

- I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

- I authorize Family Chiropractic and Acupuncture Center to leave a message on my answering machine regarding lab results/medical information relevant to patient care.

- I authorize Family Chiropractic and Acupuncture Center to talk to my spouse in regards to my lab results/medical information relevant to patient care.

- I authorize Family Chiropractic and Acupuncture Center to leave a message on my answering machine regarding account balance information.

- I authorize Family Chiropractic and Acupuncture Center to talk with my spouse in regards to my account balance information.

- I authorize payment of medical benefits to the physician. (Required Consent)

- I acknowledge that the information that I have given to Family Chiropractic and Acupuncture Center is correct and current. Any change and/or additional information will be given to them as soon as possible. If any information is incorrect or lacking, thus resulting in a delay or a denial in billing, I accept responsibility for the outstanding balance. (Required Consent)

Please Initial and Sign Below:

___ (initial) I acknowledge that I have read and understand the "Notice of Privacy Practice" form given to me by Family Chiropractic and Acupuncture Center to review. I know that I have the right to request and receive a copy of the full HIPAA disclosure form that I have just read. (Required Consent)

Signature: _____ Date: _____

Print Name: _____

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DOCTOR-PATIENT RELATIONSHIP AND INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, in most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care.

In turn, many conditions, which do not respond to chiropractic care, may be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems; however, both have made great strides in patient care.

DIAGNOSIS

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nervous system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent or otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing explanation of chiropractic care given to me. I hereby give my consent for the doctor to render chiropractic care to me.

Signature:_____ Date:_____

Print Name:_____

I have verbally informed the patient of the material risk of proposed care.

Doctor's Signature:_____Date:_____