Outline Procedure for New Patients

Step One: All new patients are requested to fill out a personal health questionnaire prior to their appointment.

Step Two: Your consultation with a doctor to discuss your health problems.

Step Three: Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if Chiropractic care is appropriate for your condition.

Step Four: You will be advised if there is the need of any additional procedures such as X-rays, MRI, & CAT Scan.

Step Five: If your case requires immediate attention, treatment will be administered.

Step Six: You will be advised as to a time you can return for your “Report of Findings” so that the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will be informed of specific recommendations in regards to your condition.

Step Seven: If appropriate, your treatment plan will begin following your “Report of Findings.”

Confidential Patient Information

Name _____ SS# _____ Date of Birth _____

Home Phone # _____ Cellular Phone # _____

Address _____ City _____ State ___ Zip _____

E-mail _____ May we send you newsletters and promotions via email? Yes____ No____

Marital Status ___ Name of Spouse _____ # of Children _____

Occupation _____ Employer _____ Work Phone _____

In case of emergency, please contact: Name _____ Phone # _____

How were you referred to our office? _____

Purpose of this appointment _____

Is your injury work related, and auto accident or personal injury? [ ] Yes [ ] No

If your injury is related to work, an auto accident or any other injury involving a claim, please advise the office staff.

Name of person responsible for payment _____ Insurance Company _____

Group # _____ ID # _____ Phone # _____

Name of the Insured _____ Birth Date of Insured _____ SS# of Insured _____

Financial Policy

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Foothill Chiropractic** will gladly prepare any necessary reports and forms to assist me in making collection from my primary insurance carrier. If I am paying by cash, check or credit card or if I have insurance co-pay and/or deductible, payment is expected at the time of service. If I have insurance, I hereby authorize and direct my insurance carrier to pay benefits, which may be due to me, according to my policy, directly to, and payable to **Foothill Chiropractic** to be applied to my account. I understand and agree that all fees for services rendered on my behalf are my personal responsibility and are due and payable at time of service.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE. IF MY TREATMENT REQUIRES INSURANCE BILLING, I HEREBY AUTHORIZE AND DIRECT **FOOTHILL CHIROPRACTIC** TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS.

Signed _____ Date _____

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 to avoid future relapses (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being (**Comprehensive Care**).

Foothill Chiropractic and Wellness Center stresses that it is always ***YOUR*** choice to choose which form of care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

□ Relief Care □ Corrective Care □ Comprehensive Care □ Would like to discuss options with the doctor

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Please list your major health concerns in order of severity:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Complaint # 1:

When did you first notice this condition? _____

Did it begin □ Immediately or □ Gradually? (please describe briefly) _____
_____

What is the exact location of your symptoms? _____
_____

Do your symptoms spread? □ No □ Yes Where?_____

How often do you experience these symptoms?
□ Constant □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
_____

Is this condition progressively □ Worsening □ Improving or □ Unchanged

What is the intensity of your symptoms? □ Severe □ Moderate □ Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain □ Deep or □ Superficial

Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like □ Throbbing

Are you experiencing any of the following associated symptoms? □ Pins & Needles □ Tingling
□ Numbness □ Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

□ Sitting ___min □ Lying □ Lifting _____lbs. □ Bowel Movements □ Hot or Cold
□ Standing □ Pushing □ Gripping □ Mental Activities □ Walking
□ Pulling □ Coughing/Sneezing □ Bright Lights □ Other (Please explain)____

Please indicate what helps you to relieve the pain.

□ Lying □ Walking □ Rest □ Medications_____
□ Sitting □ Standing □ Heat or Cold □ Other (Please explain)_____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)

Please include any other relevant history in regards to this complaint.

Complaint # 2:

When did you first notice this condition? _____

Did it begin □ Immediately or □ Gradually? (please describe briefly) _____
_____

What is the exact location of your symptoms? _____
_____

Do your symptoms spread? □ No □ Yes Where?_____

How often do you experience these symptoms?
□ Constant □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
_____

Is this condition progressively □ Worsening □ Improving or □ Unchanged

What is the intensity of your symptoms? □ Severe □ Moderate □ Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain □ Deep or □ Superficial

Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like □ Throbbing

Are you experiencing any of the following associated symptoms? □ Pins & Needles □ Tingling
□ Numbness □ Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

□ Sitting ___min	□ Lying	□ Lifting _____lbs.	□ Bowel Movements	□ Hot or Cold
□ Standing	□ Pushing	□ Gripping	□ Mental Activities	□ Walking
□ Pulling	□ Coughing/Sneezing		□ Bright Lights	□ Other (Please explain)____

_____
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Please indicate what helps you to relieve the pain.
□ Lying □ Walking □ Rest □ Medications_____
□ Sitting □ Standing □ Heat or Cold □ Other (Please explain)_____
_____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)
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Please include any other relevant history in regards to this complaint.

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Complaint # 3:

When did you first notice this condition? _____

Did it begin □ Immediately or □ Gradually? (please describe briefly) _____
_____

What is the exact location of your symptoms? _____
_____

Do your symptoms spread? □ No □ Yes Where?_____

How often do you experience these symptoms?
□ Constant □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
_____

Is this condition progressively □ Worsening □ Improving or □ Unchanged

What is the intensity of your symptoms? □ Severe □ Moderate □ Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain □ Deep or □ Superficial

Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like □ Throbbing

Are you experiencing any of the following associated symptoms? □ Pins & Needles □ Tingling
□ Numbness □ Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

□ Sitting ___min □ Lying □ Lifting _____lbs. □ Bowel Movements □ Hot or Cold
□ Standing □ Pushing □ Gripping □ Mental Activities □ Walking
□ Pulling □ Coughing/Sneezing □ Bright Lights □ Other (Please explain)____

_____
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_____

Please indicate what helps you to relieve the pain.

□ Lying □ Walking □ Rest □ Medications_____
□ Sitting □ Standing □ Heat or Cold □ Other (Please explain)_____
_____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)

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Please include any other relevant history in regards to this complaint.

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Past Medical History

Please include any of your previous conditions. If possible include dates, diagnosis, treatment received and any residuals you still suffer from.

Utero, Birth, and Infancy:

Was your mother healthy when you were in utero? □ Yes □ No (Please explain_____
_____

Did she smoke or consume alcohol? □ No □ Yes

Where were you born? _____

Were you delivered vaginally or through cesarean section? *Circle one*

Were there any complications during your birth process? □ No □ Yes (Please explain)_____
_____

Were you vaccinated? □ No □ Yes

Did you have normal neurological, structural, emotional, and social development? □ Yes □ No (Please explain) _____
_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas □ none_____
Illnesses/Hospitalizations: □ none _____
Surgeries: □ none_____

Childhood (ages 2 – 12)

Did you have normal neurological, structural, emotional, social, and academic development?
□ Yes □ No _____
_____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Athletics	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____
Surgeries: □ none_____

Teens (ages 13-19)

Did you have normal neurological, structural, emotional, social, and academic development?

□ Yes □ No _____

_____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Athletics	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas □ none_____

_____

Illnesses/Hospitalizations: □ none _____

_____

Surgeries: □ none_____

Females only: What age did you start your menses? ____ □ Regular □ Irregular

Twenties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Athletics	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Motor Vehicle Accidents □ none _____

_____

Work Injuries □ none _____

Injuries, Accidents, Falls or Traumas □ none_____

_____

Illnesses/Hospitalizations: □ none _____

_____

Surgeries: □ none_____

Thirties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Exercise Level	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐ none _____
_____
Work Injuries ☐ none _____
Injuries, Accidents, Falls or Traumas ☐ none_____
_____
Illnesses/Hospitalizations: ☐ none _____
_____
Surgeries: ☐ none_____

Forties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Exercise Level	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐ none _____
_____
Work Injuries ☐ none _____
Injuries, Accidents, Falls or Traumas ☐ none_____
_____
Illnesses/Hospitalizations: ☐ none _____
_____
Surgeries: ☐ none_____

Females only: Menopausal symptoms ☐ none ☐ yes _____

Fifties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Exercise Level	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____
Surgeries: □ none_____

Females only: Menopausal symptoms □ none □ yes _____

Sixties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Exercise Level	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____

Seventies

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor
Academics	□	□	□	□	□ _____
Exercise Level	□	□	□	□	□ _____
Emotional	□	□	□	□	□ _____
Dietary Habits	□	□	□	□	□ _____
Overall Health	□	□	□	□	□ _____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____

Eighties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor
Academics	□	□	□	□	□ _____
Exercise Level	□	□	□	□	□ _____
Emotional	□	□	□	□	□ _____
Dietary Habits	□	□	□	□	□ _____
Overall Health	□	□	□	□	□ _____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____

Nineties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Exercise Level	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐ none _____
_____
Work Injuries ☐ none _____
Injuries, Accidents, Falls or Traumas ☐ none_____
_____
Illnesses/Hospitalizations: ☐ none _____
_____

Family History

Mother □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions _____

Father □ Alive & Well, age___ □ Deceased age ___ from what?_____
Any health conditions _____

Brother □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions _____

Brother □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions_____

Sister □ Alive & Well, age___ □ Deceased age ___ from what?_____
Any health conditions _____

Sister □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions _____

Children: Ages _____ Any health conditions?_____
_____

Maternal Grandmother □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Maternal Grandfather □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Paternal Grandmother □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Paternal Grandfather □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Have any of your family members ever suffered from any of the following conditions?

□ Diabetes □ Neurological Disorders _____ □ Depression/Mental Illness
□ Heart Disease □ Autoimmune Diseases _____ □ Stroke
□ Cancer _____ □ Other_____

Medications Please list your current medications and the condition they are treating.
_____
_____
_____
_____

Vitamins and Minerals Please list your current supplements and who prescribed them.
_____
_____
_____
_____

Habits

Cigarettes □ none How many per week? _____ **Cigars** □ none How many per week? _____
Alcohol □ none How many drinks per week? _____ Type of alcohol_____
Coffee □ none How many cups per week? _____
Recreational Drugs □ none Types _____ Frequency _____Years of Usage _____
Exercise □ none Hours/Days per week _____ Types_____
Water □ none Glasses per day_____
Soft Drinks □ none Amount per week _____ Types _____
Sleep Average per night _____ Do you have difficulty falling asleep or staying asleep? □ Yes □ No
Hours desired per night? _____
Meals per days _____ What type of foods do you eat? _____
Do you consider your diet healthy? □ Yes □ No _____

DATE OF LAST

Physical Examination: _____ By Whom? _____ Results _____
Blood Work:_____ By Whom? _____ Results _____
Bone Density Study _____ Results _____ **Mammogram**_____Results_____
Pelvic Exam _____ Results _____**Self Breast Exam** _____Regularity _____
PSA level _____ Results _____ **Digital Prostate Examination** _____ Results _____
Chest X-rays _____ Results _____ **EKG** _____ Results _____
Echocardiogram_____Results_____
Spinal X-rays _____ By Whom? _____Where are they located? _____
MRI / CAT Scan _____ Re_____ Where are they located? _____
Other tests: _____

CHECK any of the following conditions you have HAD and CIRCLE anything you currently HAVE.

□ Mental Disorders □ Diabetes □ Pneumonia □ Infective Diseases___
□ Epilepsy □ Anemia □ Tuberculosis □ Fungal Infection____
□ Tumors □ Glaucoma □ Hepatitis___ □ Herpes____
□ Alcoholism □ Heart Disease □ Thyroid Disease □ Arthritis
□ Drug Addiction □ Rheumatic Fever □ Parasites □ Autoimmune Disease
□ Cancer □ Scarlet Fever □ Venereal Infection □ _____

NERVOUS SYSTEM
□ Depression
□ Memory loss/Confusion
□ Dizziness
□ Fainting
□ Convulsions
□ Numbness
□ Weakness
□ Poor Balance/Coordination
Twitches/Tremor
□ Cold/Tingling Extremities
□ Sleeping Difficulties
□ Headaches

C-V
□ Chest Pain
□ Irregular Heartbeat
□ High Blood Pressure
□ Shortness of Breath
□ Lung Problems/Congestion
□ Varicose Veins
□ Ankle Swelling

GU
□ Discolored Urine
□ Bladder Trouble
□ Painful Urination
□ Excessive Urination
□ Incontinence

EENT
□ Vision Problems
□ Flashing Lights
□ Black Spots
□ Blurriness
□ Hearing Loss
□ Ringing in Ears
□ Swallowing Difficulty

GI

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Frequent Diarrhea
- ☐ Frequent Constipation
- ☐ Hemorrhoids
- ☐ Abdominal Cramping
- ☐ Black/Bloody Stools
- ☐ Heartburn
- ☐ Digestive Problems
- ☐ Weight Problems
- ☐ Gas/Bloating After Meals
- ☐ Gall Bladder Problems
- ☐ Liver Problems

MUSCULOSKELETAL

- ☐ Jaw Pain
- ☐ Difficulty Chewing
- ☐ Face Pain
- ☐ Neck Pain
- ☐ Arm/Elbow Pain
- ☐ Wrist/Hand Pain
- ☐ Mid Back Pain
- ☐ Lower Back Pain
- ☐ Thigh/Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Difficulty Walking
- ☐ Leg/Arm Fatigue

REPRODUCTIVE

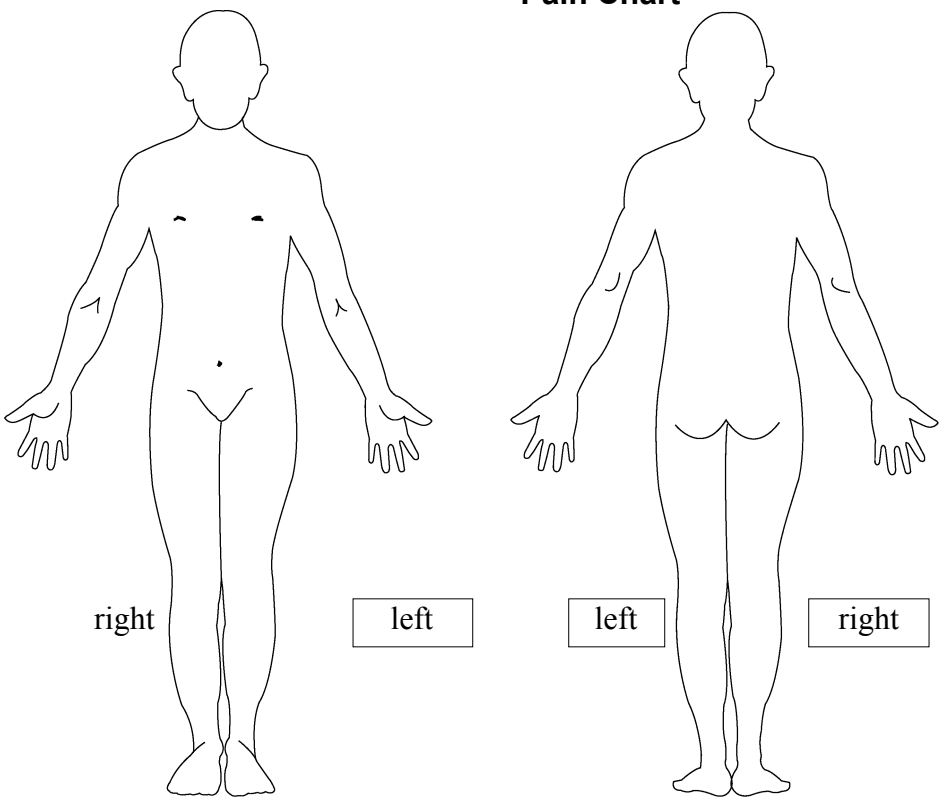
- ☐ Erectile Difficulties
- ☐ Sexual Dysfunction
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping

How often do you have a bowel movement? _____ Are your movements consistent? ☐ Yes ☐ No
Do your stools ☐ float or ☐ sink

How many times a day do you urinate? _____ Is this consistent? ☐ Yes ☐ No _____
Do you experience any urgency, dribbling, incontinence? _____

Show Area(s) of Pain or Unusual Feeling

Mark the areas on this body where you feel pain or unusual sensations. Include all affected areas.



Pain Chart

Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**