

Discover Life Chiropractic
2956 Ginnala Dr. Ste 102
Loveland, CO 80538
(970)622-0075



TO THE
New Patient
OUTLINE OF PROCEDURES FOR CARE

STEP ONE:

All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:

A consultation with the doctor to discuss your health problems and to determine what may be the cause.

STEP THREE:

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem.

STEP FOUR:

The doctor will advise you if additional laboratory tests or other tests including x-rays if needed.

STEP FIVE:

You will be given a Report of Findings at which time the cause of your problem will be discussed. You will be given a thorough explanation of how chiropractic works and how results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:

If you are accepted as a patient, chiropractic care will begin. The type of care you need will be explained to you. Also, additional explanations will be given on the different types of care available in the office.

STEP SEVEN:

An estimate of the future care that is needed will be given and upon your acceptance, adjustments will begin and continue until a maximum correction for you has been obtained.

STEP EIGHT:

After maximum correction, a schedule of care will be recommended to help prevent future problems and maintain good health.

| | |
|------|----------|
| DATE | I.D. NO. |
|------|----------|

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State/Prov: _____ Zip/Postal Code: _____
Home Phone: _____ Birth Date: _____ Age: _____ Sex: M F
Social Security # _____ Driver's License Number: _____
Social Insurance # _____ Circle One: Married Single Widowed Divorced Separated
Business Employer: _____ Type of Work: _____
Business Phone: _____ Spouse's Social Security # _____
Name of Spouse _____ Spouse's Social Insurance # _____
Spouse's Employer _____ Business Phone _____
Type of Work _____ Names and Ages of Children _____
Referred To This Office By: _____
Name and Number of Emergency Contact: _____ Relationship: _____
Who Is Responsible For Your Bill, You and Spouse Workers' Comp. Auto Insurance Medicare Medicaid
 Personal Health Insurance (Name) _____ Health Card # _____

CURRENT HEALTH CONDITION

Purpose of This Appointment _____
Other Doctors Seen For This Condition: Yes No Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
Date of Accident: _____ Time of Accident: _____
Have You Made A Report of Your Accident To Your Employer: Yes No
Drugs You Now Take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine
 Insulin Other _____
Do You Wear A Shoe Lift? Yes No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Please Check and Describe:
Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery
 Broken Bones Other _____
Major Accident or Falls: _____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: None Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD 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
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

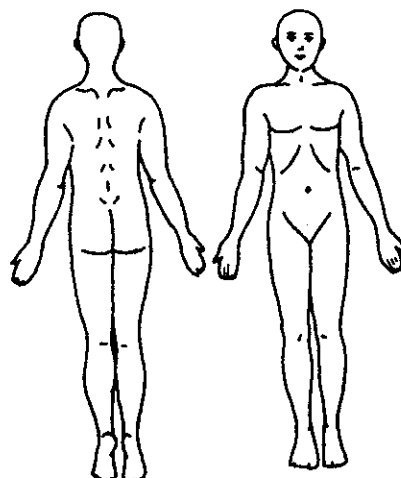
- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- Yes No Not Sure



Please outline on the diagram the area of your discomfort

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

C-V-R CODE

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

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

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

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted: Yes No Referred

Doctor's Signature

Discover Life Chiropractic

Name: _____

Date: _____

Diet and Exercise Questionnaire

If I were to describe my diet it would be:

Poor Average Good Excellent

Please write an example of daily food consumption:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you eat at regularly scheduled times? Yes No Sometimes

How many ounces of water do you drink in a day? _____

Do you exercise? If so, please describe what you do and how often:

Do you supplement with vitamins or other nutritional products? Yes No

If so, are you consistent? Yes No

Please list the supplements and brand names.

Please list any medications you are now taking.

How many hours per night do you sleep? _____

Is it restful? Yes No

What position do you sleep in? Back Side Stomach

Please describe your daily work or routine

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). 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

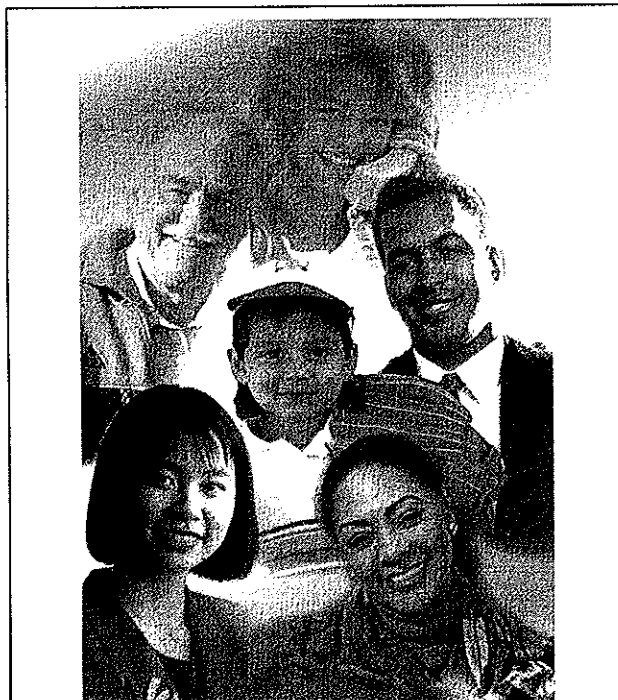
Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Date _____

Patient's Signature _____

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's 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, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, is for examination and x-rays only. The X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____

Date _____

Guardian or Spouse's Signature of Authorizing Care _____

Date _____