

# The doctors and staff are happy to welcome you to Health Plus!

We want you to feel comfortable as you become a new patient in our office.

Please read this step by step outline of **“What to expect.”**

- 1 The purpose of today’s visit is to determine the cause of your health problem. This first step requires everyone to fill out this *Personal Health History Questionnaire*.
- 2 When you complete this form, you will *meet privately with the Doctor of Chiropractic* to discuss your health problems and any concerns you may have.
- 3 An appropriate *examination and evaluation* will follow including tests necessary to determine the precise cause of your health problems.
- 4 You will be *scheduled* for a *Report of Findings* to go over the results of this first visit along with any recommendations for treatment.
- 5 On your *Report of Findings visit* you will be given:
  - a thorough explanation of your problem
  - recommendations for the type of treatment, treatment schedule, and anticipated length of care necessary to attain the best possible results
  - the cost of your treatment will be given to you at that time including any applicable insurance coverage and the amounts that you will need to pay
- 6 Our *office procedures, payment options, and your treatment schedule* will be explained to you.
  - If we can accept you as a patient, chiropractic care will begin right at this point and we will follow your treatment schedule so that a maximum correction for your condition can be obtained.
- 7 You will be scheduled for an *Extended Doctor’s Report* where you will be given a through explanation of how our treatment works and things that you can do at home to help the process along. (Please bring someone along with you, there’s a lot to learn).
- 8 All along the way of your treatment schedule, your *improvements will be monitored* so that we make sure that we get the best results possible
- 9 After maximum correction has been attained, *recommendations will be made for future care* to help prevent future problems and maintain good health.



*Confidential Patient Health Record*

## PERSONAL HEALTH HISTORY

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work: Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex:  male  female

E-mail: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Marital status:  Single  Married  Divorced  
 Widowed  Separated

Title:  Mr.  Ms.  Mrs.  Miss  
 Dr.  Rev.  Hon.

Work Status  unemployed  full time  
 part time  retired  disabled-not working  
 self-employed

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ ~ \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Spouse's Health Insurance #: \_\_\_\_\_

Spouse's SSN #: \_\_\_\_\_

Spouse's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Employer \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Type of Work \_\_\_\_\_

Names and Ages of Children: \_\_\_\_\_

\_\_\_\_\_

Referred To This Office By: \_\_\_\_\_

Name of a person to Contact in an Emergency: \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ ~ \_\_\_\_\_ Relationship: \_\_\_\_\_

Who Is Responsible For Your Bill, You and:  Spouse  Workers' Comp.  Auto Insurance  
 Medicare  Medicaid  Personal Health Insurance

Name of Insurance Co. \_\_\_\_\_ Health Card # \_\_\_\_\_

(Please give the front desk your insurance card so that we can make a copy)

### CURRENT HEALTH CONDITION

**Purpose of This Appointment** *(Please describe your chief health complaint):* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you seen other Doctors for this Condition?  Yes:  No If so, who? Dr. \_\_\_\_\_

Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_

When Did This Condition Begin? \_\_\_\_\_ Has This Condition Occurred Before?  Yes  No

Is this 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  Others: \_\_\_\_\_ Do You Wear A Shoe Lift?  Yes  No

## PAST HEALTH HISTORY

**Please Check  and Describe:**

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?  Yes  No  
If so, \_\_\_\_\_  
\_\_\_\_\_

Major Surgery/Operations:

- Appendectomy
- Tonsillectomy
- Gall Bladder  Hernia
- Back Surgery
- Broken Bones
- Other \_\_\_\_\_
- Other \_\_\_\_\_

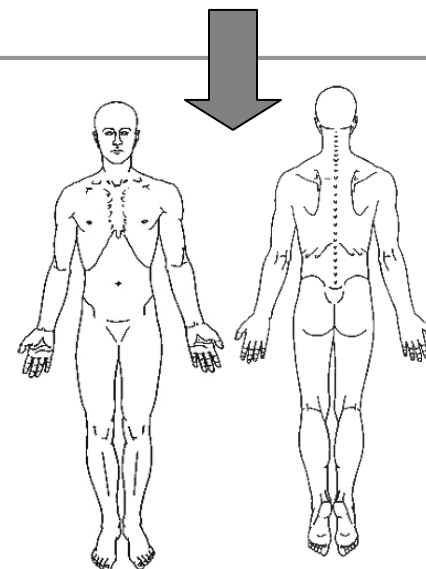
Major Accident or Falls: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalization (Other Than Above): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Chiropractic Care:

- Yes:  No If so, who?
- Dr. \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_
- Approximate Date of last visit \_\_\_\_\_

Please outline on this diagram areas of your current discomfort:



Below are lists 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:**

- Pneumonia
- Rheumatic Fever
- Polio
- Tuberculosis
- Whooping Cough
- Anemia
- Measles
- Mumps
- Small Pox
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Thyroid
- Tested HIV positive
- Influenza
- Pleurisy
- Arthritis
- Epilepsy
- Mental Disorders
- Lumbago
- Eczema
- INTAKE**
- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

**CHECK  ANY OF THE FOLLOWING YOU HAVE HAD IN 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
- General Stiffness
- NERVOUS SYSTEM**
- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- EENT**
- Ear Aches
- Hearing Difficulty
- Stuffed Nose
- Dental Problems
- Sore Throat
- Vision Problems

### GENERAL

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

### GASTROINTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- 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

**CARIDOVASCULAR**

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

**MALES ONLY:**

- Prostate Problems
- Sexual Dysfunction
- Breast Pain/Lumps
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**FEMALES ONLY:**

- When was your last period?  
\_\_\_\_\_
- Are you pregnant?  
 Yes  No  Not Sure
- Menstrual Irregularity
  - Menstrual Cramps
  - Vaginal Pain/Infection
  - Breast Pain/Lumps
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_
  - Other \_\_\_\_\_

**FAMILY HISTORY:**

The following members have a same or similar problem as I do:  Mother  Father  
 Brother  Sister  Spouse  
 Child

**Any Additional Comments or Concerns:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Consent for Treatment**

I, the undersigned, hereby authorize the Doctors of Health Plus Wellness and whomever they may designate as their assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **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.**

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Witness: \_\_\_\_\_

**Authorization to Release Medical Information**

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Witness: \_\_\_\_\_

**Request for Payment of Benefits to Provider of Care**

I hereby authorize the \_\_\_\_\_ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Health Plus Wellness the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Witness: \_\_\_\_\_

**Consent for Treatment of Minor**

I hereby authorize the Doctors of Health Plus Wellness and whomever they may designate as their assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as they deem necessary to my \_\_\_\_\_ (indicate relationship of child) \_\_\_\_\_ (Child's name)

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Witness: \_\_\_\_\_