



Patient Health History

Today's Date / / Signature of Patient _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth / / Age _____ Gender (check one) Male Female Unspecified

Marital Status (check one) Single Married Other SSN _____

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Race (check one)

White Black/African American Hispanic American Indian/Alaskan Native
 Asian Asian Indian Chinese Filipino
 Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
 Samoan Guamanian or Chamorro Other _____ I choose not to specify

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

English Spanish American Sign Language Chinese French German
 Tagalog Vietnamese Italian Korean Russian Polish
 Arabic Portuguese Japanese French Creole Greek Hindi
 Persian Urdu Gujarati Armenian I choose not to specify

Continued ...

Verification Question (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
 What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
 What was the make of your first car? When is your anniversary? What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10
No interest *Very Interested*

Current medications, including dosage if known.

If there are no current medications, check here:

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

List any known allergies you have had to any medications.

If no allergies are known, check here:

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? Yes No

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____ / _____

Is it okay to call you at work?

- Yes No

How did you hear about our clinic? Or who referred you?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Billboard | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Newspaper ad | <input type="checkbox"/> TV Commercial | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio | <input type="checkbox"/> Other |

If you selected 'Yellow Pages' please indicate which Yellow Pages:

If you selected 'family member', 'friend', or 'physician' please enter their name below:

If you selected 'other' please describe

Medical Conditions:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke |

Surgeries:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies | <input type="checkbox"/> Radical prostatectomy | <input type="checkbox"/> Transurethral prostate surgery |

Allergies:

- | | | | |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Wheat/Gluten | |

Social History:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally | <input type="checkbox"/> Caffeine used often | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often |
| <input type="checkbox"/> Drink alcohol occasionally | <input type="checkbox"/> Drink alcohol often | <input type="checkbox"/> Exercise not at all | <input type="checkbox"/> Exercise occasionally |
| <input type="checkbox"/> Exercise often | <input type="checkbox"/> Experience stress occasional | <input type="checkbox"/> Experience stress often | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always | <input type="checkbox"/> Wear seat belts never | <input type="checkbox"/> Wear seatbelts usually |

Family History:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent) | <input type="checkbox"/> Arthritis (sibling) | <input type="checkbox"/> Cancer (parent) | <input type="checkbox"/> Cancer (sibling) |
| <input type="checkbox"/> Cholesterol (parent) | <input type="checkbox"/> Cholesterol (sibling) | <input type="checkbox"/> Diabetes (parent) | <input type="checkbox"/> Diabetes (sibling) |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent) | <input type="checkbox"/> Psychiatric (sibling) | <input type="checkbox"/> Stroke (parent) | <input type="checkbox"/> Stroke (sibling) |
| <input type="checkbox"/> Thyroid (parent) | <input type="checkbox"/> Thyroid (sibling) | | |

Substance Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past) | <input type="checkbox"/> Alcohol (present) | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past) | <input type="checkbox"/> Cocaine (present) |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroin (past) | <input type="checkbox"/> Heroin (Present) |
| <input type="checkbox"/> Marijuana (past) | <input type="checkbox"/> Marijuana (present) | | |

Male Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Female Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

Occupational Activities:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Daycare/childcare | <input type="checkbox"/> Executive/legal | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor | <input type="checkbox"/> Home services |
| <input type="checkbox"/> Household | <input type="checkbox"/> Light manual labor | <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Medium manual labor |

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular:

	No _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Respiratory:

	No _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Allergic/Immunologic:

	No _____		
	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Genitourinary:

	No _____		
	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Ears/Nose/Throat:

	No _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Gastrointestinal:

	No _____		
	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Eyes:

	No _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Musculoskeletal:

	No _____		
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Hematologic/lymphatic:

	No _____		
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Integumentary:

	No _____		
	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Neurologic:

	No _____		
	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Psychiatric:

	No _____		
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Endocrine:

	No _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

Constitutional:

	No _____		
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

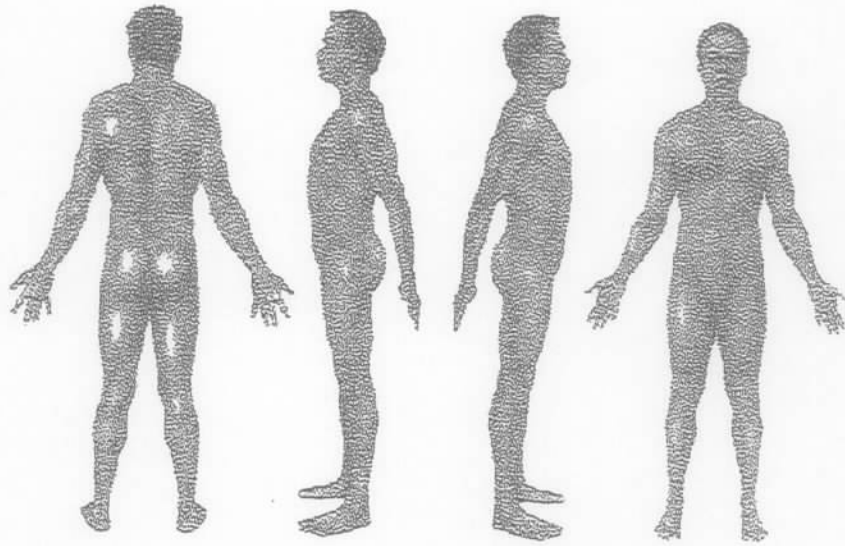
= Numbness

X = Burning

/ = Stabbing

0 = Pins & Needles

+ = Dull Ache



Describe your symptoms: _____

When did your symptoms start? Month _____ Day _____ Year _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
 Frequently (51-75% of the day)
 Occasionally (26-50% of the day)
 Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp Dull ache Numb Shooting
 Burning Tingling Stabbing

How are your symptoms changing?

- Getting better Not changing Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- 0 None 1 2 3
 4 5 6 7
 8 9 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- Not at all A little bit Moderately Quite a bit
 Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- All of the time Most of the time Some of the time A little of the time
 None of the time

In general, would you say your overall health right now is....

- Excellent Very good Good Fair
 Poor

Who have you seen for your symptoms:

- No one Other Chiropractor Medical Doctor Physical Therapist
 Other

What treatment did you receive for your symptoms?

- Adjustments Physical Therapy Medication Surgery
 Other

When did you receive this treatment?

- In the last month 2 - 3 months ago 3 - 6 months ago 6 months to 1 year ago
 1 - 2 years ago 2 - 5 years ago 5 - 10 years ago

What tests have you had for your symptoms?

- X-rays MRI CT Scan Other

When were these tests done?

- In the last month 2 - 3 months ago 3 - 6 months ago 6 months to 1 year ago
 1 - 2 years ago 2 - 5 years ago 5 - 10 years ago

Have you had similar symptoms in the past?

- Yes No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- This Office Other Chiropractor Medical Doctor Physical Therapist
 Other

What is your occupation?

- Professional/Executive White Collar/Secretarial Tradesperson Laborer
 Homemaker Full-time Student Retired Other

If you are not retired, a homemaker or a student, what is your work status?

- Full-time Part-time Self-employed Unemployed
 Off work Other

Thank you. Please return to the front desk.

INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VCS, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern 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

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: Latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the chiropractic procedures. Sometimes the response is phenomenal. 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 chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of policy.

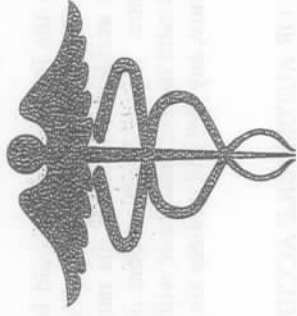
I have read, and understand the foregoing.

DATE

SIGNATURE

Deere Road Chiropractic, Ltd.

FINANCIAL POLICY



I have read and understand the payment policy of Deere Road Chiropractic, Ltd. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Deere Road Chiropractic, Ltd. and my insurance company. I request that Deere Road Chiropractic, Ltd. prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Deere Road Chiropractic, Ltd. that fees will be due and payable immediately.

Patient's signature (or guardian if patient is a minor)

Date

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name: _____

Insurance Deductible: _____

Deductible as yet unsatisfied: _____

Co-Insurance Percentage: _____

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

1. We request that 100% of the first visit be paid at the time of the first visit.
 2. For your convenience, payment may be arranged at the last visit of each week.
 3. We are happy to accept cash or a check at this time.
- We offer a 10% discount for payment at time of service for those who would like to file your own insurance or have no insurance.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

HEALTH INSURANCE AND MANAGED CARE

Please present your insurance card to the receptionist. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file with your company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible.

We are not certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office pay any deductible and any co-pay as stated in your policy.

When all insurance checks have been received, we will refund any overpayment to you.

CANCELLED APPOINTMENTS

A 24-hour notice is required for cancelled appointments. There is a \$33.00 charge for missed appointments. Insurance companies do not cover missed appointment fees.