

Confidential Patient Information

Date: _____

Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #s: (H) _____ (C) _____ (W) _____

Age: _____ Birth Date: _____ Sex: _____ No. of children: _____ Children's ages: _____

Marital Status: Married/Partner name: _____ Single _____ Divorced _____ Widowed _____

Occupation: _____ Employer: _____

Business Address: _____

Referred to our office by: _____

Contact in case of emergency: _____ Phone: _____

Address: _____

Please describe present complaints

#1: _____

When did this begin? _____

What caused it? _____

Have you had same or similar condition before? _____

Have you received treatment? _____

If yes, where, when & what results? _____

Problem is: Getting worse Constant Comes and goes

What makes the problem worse? _____

Problem interferes with: Work Sleep Daily Routine Other

#2: _____

When did this begin? _____

What caused it? _____

Have you had same or similar condition before? _____

Have you received treatment? _____

If yes, where, when & what results? _____

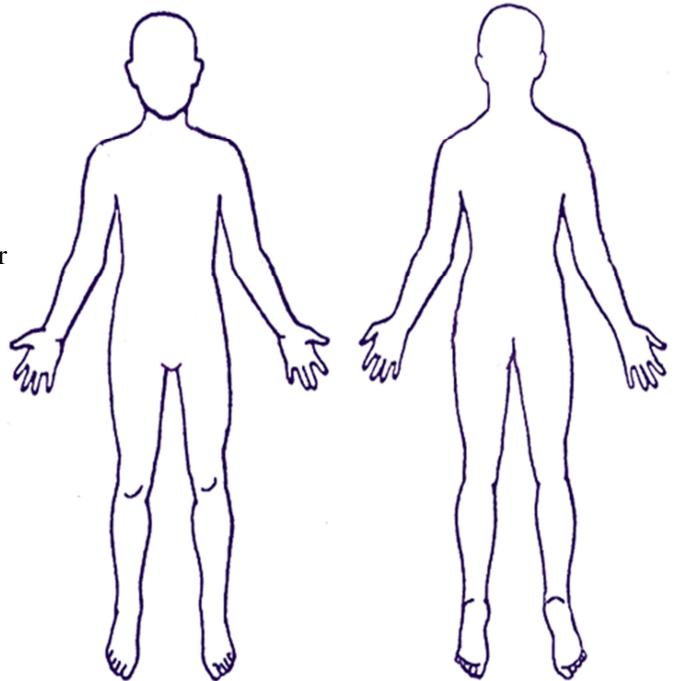
Problem is: Getting worse Constant Comes and goes

What makes the problem worse? _____

Problem interferes with: Work Sleep Daily Routine Other

Other health concerns:

Indicate areas of pain on figures below:



Front

Back

Patient name: _____

Circle Current Conditions

Check Former Conditions

Musculo-Skeletal

Headache
Neck/Shoulder/Arm Pain
Stiff Neck
Pain between shoulders
Numbness
Low back/Leg pain
Arthritis
Bursitis
Swollen joints
Painful tailbone
Foot trouble
Muscle weakness
Tremors
Spinal curvature (scoliosis)
Poor posture

Cardio-Vascular

Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Pain over heart
Swelling of ankles
Poor circulation

Skin

Skin eruptions/Rash
Itching
Dryness
Bruises easily
Varicose veins
Hives
Exzema/Psoriasis
Shingles

Respiratory

Chest pains
Chronic cough
Difficulty breathing
Spitting up blood
Spitting up phlegm
Asthma/Wheezing
Hayfever

General Symptoms

Allergy
Fever
Chills
Sweats
Fainting
Dizziness
Nervousness/Irritability
Convulsions
Loss of sleep/Poor sleep
Fatigue
Loss of weight
Cold hands or feet
Depression

Genito-Urinary

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection/stones
Bed wetting
Bladder infection
Prostate trouble

Gastrointestinal

Poor appetite
Difficult digestion
Excessive hunger
Belching/Gas
Nausea
Vomiting
Distension of abdomen
Abnormal thirst
Constipation
Diarrhea
Colon trouble
Colitis/Irritable Bowel
Hemorrhoids
Rectal bleeding
Intestinal parasites
Liver trouble
Gall bladder trouble

Eyes, Ears, Nose, & Throat

Frequent colds
Sore throats/Tonsillitis
Thyroid problem
Poor vision
Deafness
Earache
Ear discharge
Ear noises
Nose bleeds
Sinus trouble
Dental decay
Gum trouble
Fever blisters

Check the following conditions you have had

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | Type _____ |
| Type _____ | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever | |
-

Patient name: _____

Family Medical History (check any that apply)

- Asthma
- Allergies
- Alzheimer's
- Arthritis
- Cancer
- Other (specify) _____
- Cardiovascular disease
- Diabetes
- Kidney disease
- Mental illness/depression
- Stroke

Personal Medical History

List any **accidents** or **injuries** you have had and when they occurred: _____

List any **surgeries** you have had, please give dates:

List **hospitalization** and/or **major illnesses** and dates:

List any prescription or over-the-counter (OTC) drugs you have taken for **any length of time:** (eg. Tums, Tylenol, etc.)

List prescription or OTC drugs you **currently** take:

List any **herbs, vitamins, or homeopathics** you take:

Y N Have you ever seen a chiropractor before?

Name: _____

Last visit _____

What were the results? _____

Name of family doctor _____

Give dates of your:

_____ Last physical exam

_____ Last dental check-up

_____ Last eye exam

Y N Do you wear orthotics or foot support?

Y N Are you exposed to herbicides or pesticides in or around your home?

Y N Are you exposed to or in contact with chemicals or fumes in your work place?

Y N Have you recently been exposed to new carpet, paint, furniture, car, etc.?

Y N Do you or did you use a microwave oven?

Y N Do you or did you use aluminum pans?

Y N Body deodorants that contain aluminum?

Do you follow a particular diet? Which _____

Y N Are you Vegan/Vegetarian? (circle one)

How much water do you drink per day? ___glasses
Type? (circle) city, bottled, distilled, spring

What do you drink?

___cups/day coffee ___cups/day tea

___cans/day soda ___regular ___diet

___beers/wk ___glasses wine/wk ___mixed drinks/wk

Y N Do you smoke? ___packs/day

Do you eat: (mark approx. how often per week)

___chocolate ___spicy foods

___sugar ___fried foods

___ice cream ___popcorn

___pastries ___shellfish

Patient name: _____

Women Only Gynecological History

Date of last menstrual cycle _____ Length of cycle _____ Time between cycles _____
Any recent changes in normal menstrual flow? _____ Age at first period _____
Number of children _____ Number of pregnancies _____ Number of C-sections _____ Number of Miscarriages _____
Date of last gynecological exam (PAP, mammogram) _____ Results _____
Are you currently using any method of birth control? Yes No If Yes, what method? _____
If birth control pills? Type _____ Dates used _____
Have you ever (or currently) used any bio-identical hormones (i.e. DHEA, progesterone, estrogen, testosterone)? Y N
If yes, what dose and length of time. _____ Are you pregnant? Yes No
Do you have: Endometriosis _____ Infertility _____ Fibrocystic breasts _____ Fibroids _____ Ovarian cysts _____
Reproductive cancer _____ Pelvic inflammatory disease _____ Genital Herpes _____ STD _____
If menopausal, how was the transition? _____

Check the symptoms you experience regularly one to two weeks before your period:

- Anxiety
- Irritability/Aggressiveness
- Engage in self-destructive behavior
- Weight gain
- Abdominal bloating
- Tender, swollen and/or painful breasts
- Craving for sweets
- Increased appetite
- Fatigue
- Headaches
- Shaky or clumsy
- Depressed
- Insomnia/difficulty sleeping

Check the symptoms and/or behaviors that occur during your period:

- Cramping in lower abdomen or pelvic area
- Low back aches
- Diarrhea
- Nausea or vomiting
- Headaches
- Unusual fatigue
- Weight gain/bloating
- Painful and/or swollen breasts
- Irritability/ Mood swings
- Depression

Check any of the following statements that describe your menstrual cycle, energy level or reproductive function:

- Heavy prolonged menstrual bleeding/clotting
- Menstrual bleeding that exceeds 5 days
- Absence of periods for 3 months or more
- Vaginal itching, burning, dryness
- Menstruation that occurs too frequently (21-24 days)
- Irregular periods (once every 3-6 months)
- Menstrual cycle 36 days or longer
- Unusually light or heavy periods
- Bleeding or spotting between periods
- Abnormal vaginal discharge
- Frequent urination

Check the symptoms that occur throughout the month:

- Hot flashes/night sweats
- Incontinence/Urinary leakage
- Vaginal infections
- Vaginal discharge
- Change in sexual desire
- Difficulty with orgasm
- Painful intercourse

Patient name: _____

Welcome to Healthspring Holistic Center

In our office we use Applied Kinesiology and many other techniques. These are specialized techniques within chiropractic and, therefore, require certain office procedures. In order to facilitate your treatment:

1. Wear or bring comfortable, loose clothes if possible (shorts, sweat suits, etc.). Gowns are also provided.
2. No perfume or cologne please. Many of our patients are sensitive to scents and chemicals.
3. Remove jewelry, especially necklaces, earrings, and watches before treatment. This is for your safety and our convenience.

Fees:

New patient exam and treatment (approximately 1 hour)	\$225.00
Regular office visit/adjustment (approximately 20 minutes)	\$80.00
Limited office visit/adjustment (approximately 10 minutes)	\$60.00
Extended office visit/adjustment (approximately 30 minutes)	\$115.00
Double office visit/adjustment (approximately 40 minutes)	\$150.00
Brief office visit/adjustment (approximately 10 minutes) (children under 6 years old)	\$40.00

Financial Policy:

- Payment is due in full for all services rendered at the time of your visit. We accept cash, personal checks, VISA, MasterCard, and Discover. We do not accept or file insurance.
- We will provide you with a superbill to file with your insurance carrier, if you so desire. There is a \$15 charge per claim should you need any further paperwork and/or phone calls from our office to your insurance carrier. Ultimately, all disputes between you and your carrier are your responsibility.
- We do accept patients over 64, however, we do not accept Medicare assignments. If you are a participant in the Medicare Part B program, you will be required to sign a waiver of liability. The doctor or receptionist will explain out Medicare procedures to you as there are specific state law requirements we must follow.
- If you are requesting treatment as the result of an automobile accident or an on-the-job injury, please let us know immediately.
- All nutritional supplements, books, orthopedic supports or any other items purchased must be paid for in full at the time of purchase. Our 100% Money Back Guarantee: If your find you cannot take any of the recommended supplements for any reason, you can bring them back for an exchange or full refund within 30 days of purchase.

Cancellation Policy

We have a **24-hour notice requirement** for cancellation of appointments. If you miss an appointment without proper notification you will be asked to pay for it before another appointment is scheduled. Please make every effort to be on time for your appointments.

Your signature below indicates your understanding of our policies and expectations.

Signature

Date