CENTER FOR ALTERNATIVE MEDICINE

NEW PATIENT PACKET

Personal History

Date: _____

ABOUT YOU

Name: _____ Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Cell Phone # _____ Email Address: _____

Social Security# _____ Check one: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: _____ Type Of Work: _____

Business Phone: _____ Driver's License Number: _____

Name Of Spouse: _____ 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

CURRENT HEALTH CONDITION

Purpose Of This Appointment: _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No Who? _____

Type Of Treatment: _____ Results: _____

Would you like us to inform your Doctor about your treatment? ☐ No. If yes, who? _____ Phone# _____

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 To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin ☐ Other _____

Do You Suffer From Any Condition Other Than that Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Surgery: ☐ Appendectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Broken Bones ☐ Other: _____

Hospitalization (Other Than Above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's name & Approximate Date Of Last Visit: _____

Personal History CONTINUED

Patient name: _____

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:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ 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

NERVOUS SYSTEM CODE

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

GENERAL CODE

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

GASTRO-INTESTINAL CODE

- ☐ 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 CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

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

EENT CODE

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

MALE/FEMALE CODE

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

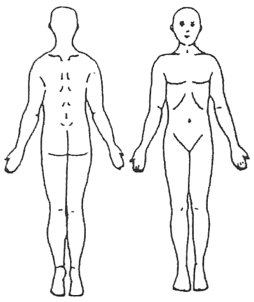
FEMALES ONLY:

When was your last period?

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

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

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Other

DO NOT WRITE BELOW THIS LINE

Chiropractic Analysis: _____

Diagnosis: _____

Patient Accepted: ☐ Yes ☐ No ☐ Referred Doctor's Signature: _____

CENTER FOR ALTERNATIVE MEDICINE

NEW PATIENT PACKET

Health History & Lifestyle

Date: _____

YOUR HEALTH CONCERN

Name _____

What is the reason for your visit? _____

_____

What do you think caused your problem? _____

When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐ No

What type(s) of therapy have you tried for this condition?

☐ conventional drugs ☐ chiropractic ☐ acupuncture ☐ diet modification
☐ vitamin/minerals ☐ herbs ☐ homeopathy ☐ other _____

Laboratory tests performed (e.g. blood, urine, stool, hair analysis) _____

_____

Outcome of tests _____

What diagnosis were you given? _____

Is your health currently: ☐ getting better ☐ getting worse ☐ staying the same

How do you know? _____

Please list any other health concerns/conditions, even if you think they may not be important.

_____

_____

Primary care physician _____ Date of last physical exam _____

MEDICATIONS & HISTORY

Please list all medications you have taken over the past 3 months (prescription or over the counter)

DRUG NAME	START DATE	STOP DATE	REASON FOR IT	RESULTS

Please list all hospitalizations or surgeries

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____

Have you EVER been on frequent or prolonged antibiotic therapy? ☐ Yes ☐ No

Any medical devices/prosthetics/implants ☐ Yes ☐ No describe _____

BACKGROUND

Do you have amalgam (silver) dental fillings? ☐ Yes ☐ No

Please list any allergies or food sensitivities: _____

How was your health as a child: ☐ excellent ☐ good ☐ fair ☐ poor

Were there any complications with your gestation (pregnancy) or delivery? ☐ Yes ☐ No

If yes, please explain _____

Were you breast-fed? ☐ Yes ☐ No How long? _____

WOMEN

Age at onset of menstruation _____ Are you pregnant? ☐ Yes ☐ No

Age at onset of menopause _____ Hysterectomy ☐ Yes ☐ No

Number of children _____ Number of miscarriages _____

Length of menstrual cycle _____ days Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g. heavier, larger clots, scanty) _____

LIFESTYLE

Occupation _____

Is your job associated with potentially harmful chemicals (e.g. pesticides, solvents) ☐ Yes ☐ No

On a scale of 0-10 (10 being the highest) circle your level of stress: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How does this affect you? _____

Major causes of your stress: _____

Do you regularly practice any form of stress reduction, yoga or meditation? ☐ Yes ☐ No

Rate your current emotional health: ☐ excellent ☐ good ☐ fair ☐ poor ☐ unstable ☐ crisis

Are you currently in psychotherapy? ☐ Yes ☐ No

Does your home environment have a supportive effect on your health? ☐ Yes ☐ No

How many hours of relaxation (not including sleep) do you give yourself during the week? _____ During weekends? _____

Favorite relaxing activities? _____

Do you drink purified water? ☐ Yes ☐ No If yes, what type? _____

Do you use an air purifier? ☐ Yes ☐ No

Do you eat organically grown foods? ☐ Yes ☐ No What % of your diet? _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right

Lowest adult weight _____ Highest adult weight _____ Desired weight _____

Any unintentional weight loss or gain of 10 pounds or more in the last three months? ☐ Yes ☐ No

How often do you move your bowels? _____

SLEEP & HABITS

How is your sleep? ☐ excellent ☐ good ☐ fair ☐ poor

How many hours do you sleep? _____ Do you wake rested? ☐ Yes ☐ No

Do you go to bed and wake up at about the same time each day? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No _____ packs/day How many years _____

Do you smoke cigars? ☐ Yes ☐ No _____ cigars/day How many years _____

Do you drink alcohol? ☐ Yes ☐ No _____ drinks/ week

How many cups of water do you drink each day? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, what kind and how often? _____

Are you on a special diet? ☐ Yes ☐ No If yes, what kind? _____

DIET

Please list everything you eat and drink for 3 days.

	BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK
DAY 1						
DAY 2						
DAY 3						

How often do you eat in restaurants? _____ times a week

What foods do you crave? _____

Please list all supplements / herbs / homeopathics you are currently taking.

NAME/TYPE	DOSAGE	REASON FOR IT

Please list your special interests and passions: _____

CENTER FOR ALTERNATIVE MEDICINE

Context of Care

Date: _____

ABOUT YOUR CARE

Name _____

1. Why did you choose to come to this clinic instead of another?

2. What frustrations have you experienced at other clinics?

3. What do you want to take place over the course of your care here?

4. How long do you feel this will take?

5. What might it cost you if you don't significantly improve your lifestyle and any other factors contributing to poor health?

6. What is your present level of commitment to addressing any underlying causes of your signs and symptoms? (1-10 with 10 being the most)

7. What potential obstacles do you foresee in addressing the lifestyle factors affecting your health, and following the recommendations we are sharing with you?

8. Who would be willing to support you in your health goals?

WOULD YOU LIKE TO:

- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be more muscular
- ☐ Be less moody
- ☐ Be more decisive
- ☐ Improve your memory
- ☐ Sleep better
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited diseases (e.g. cancer, heart disease)
- ☐ Be stronger
- ☐ Be thinner
- ☐ Improve your skin
- ☐ Be less depressed
- ☐ Think more clearly
- ☐ Be free of pain
- ☐ Get less colds and flu's
- ☐ Slow the aging process

CENTER FOR ALTERNATIVE MEDICINE

Acknowledgement of Self Payment Practice

Our office is a Self Pay Practice. **WE DO NOT ACCEPT or BILL ANY INSURANCE.** All services are self pay at time of service.

WE ARE A NON PARTICIPATING MEDICARE PROVIDER. Medicare will not reimburse you for our fees.

The following is a list of our services and prices. The doctor will discuss his recommendations with you prior to treatment.

SERVICES AND PRICES

Initial Consult and Exam	$25: 15 minutes $50: 30 minutes $75: 45 minutes $100: 60 minutes
Office Visit 1: One area adjustment	$45
Office Visit 2: Full spine adjustment	$65
Office Visit 3: Full spine adjustment with extremities	$80
Ultrasound/Combo	$25/area
Acupuncture	$75
Acupuncture with Electric Stimulation	$85
Nasal Specific Technique	$65
Radial Pressure Wave	$45/area
Laser	$50/area

Missed Appointment Fee: $50. We require 24 hours notice of cancellations.

PATIENT NAME (PLEASE PRINT) _____ SIGNATURE _____ DATE _____

CENTER FOR ALTERNATIVE MEDICINE

Agreement Concerning Scope of Care

Dear Patient,

You have come to us with the desire to improve your general health through Complementary and Alternative Medicine (CAM). You may or may not at the same time be under the care of another physician for primary care or for a specific ailment. It is important to understand clearly the scope and extent of CAM which we expect to render in your case. Since nutritional deficiency may or may not be associated with a specific disease, or may be the cause of that disease, or may occur as a result of that disease, our concern in your case will be with your nutritional program and your lifestyle and your ability to metabolize and utilize the nutrients you consume. If you have a specific disease and desire treatment for that specific disease entity, you should place yourself under the care of a specialist for such diagnosis and treatments as may be indicated or desired by you.

In our lifestyle changes, CAM and nutritional management of your case, we may prescribe vitamins, herbs, minerals, enzymes, and naturopathic and nutritional supplements. The purpose of these natural prescriptions is limited to

- Improvement of your overall nutritional status
- Improvement of your metabolism
- Increasing your sense of well-being
- Normalizing your appetite
- Reducing your pain and discomfort
- Balance your mind body constitution

It is important to understand that you may not receive any of these benefits. Results do not occur predictably in every patient, and in some cases they do not occur at all.

Our viewpoint concerning Complementary and Alternative Medicine (CAM) and the diagnostic evaluation of disease is not necessarily shared by the American Medical Association, the Food and Drug Administration, the American Cancer Society, the Arthritis Foundation, the American Heart Association or similar agencies or organizations. Though significant evidence exists to consider such diagnostics and natural treatments safe and effective, the above agencies or organizations may consider them unproved, investigational or experimental. Signing below you acknowledge that, with full knowledge of these disagreements, you desire to undertake diagnostic evaluation and have prescribed in your case such nutritional supplements and natural treatments which, in our opinion, appear to be indicated in your condition.

I have read and understand the above. Under conditions indicated, I hereby place myself under your care for such diagnosis, care, treatment, prescription, and therapies that are indicated in your judgment.

PATIENT	DATE	WITNESS