CHIROPRACTIC
Bringing Out The Best In You

Patient _____
Doctor _____
Date _____ Case # _____

○ New Patient

Welcome To Our Office

Name _____ Preferred name _____
Address _____
City/State/Zip _____
Phone #s (home) _____ (cell) _____
Is it okay to contact you at work? ❍ no ❍ yes Work # _____
E-mail address _____ Web site _____
SS# _____ Birthdate _____ Age _____
Occupation _____ Employer _____
Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed
Spouse's name _____ Phone #(s) _____
Children's names and ages _____
_____
Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) _____
_____
Emergency contact: Name _____
Relationship _____ Phone #(s) _____
Favorite hobbies or interests _____

What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes
If yes, please tell us the doctor's name _____
Were you pleased with your care? ❍ no ❍ yes
How did you find out about our office? _____
Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other _____
When did the incident occur? _____
Attorney (if applicable) _____ Phone _____
Are you receiving care from other health professionals? ❍ no ❍ yes
If yes, please name them and their specialty _____
_____
Please list any drugs or medications you are taking _____
_____
_____
Please list any vitamins/herbs/homeopathics/other you are taking _____
_____
_____
Are you pregnant? ❍ no ❍ yes If yes, what month? _____

Current Health

What are your most pressing health concerns? _____

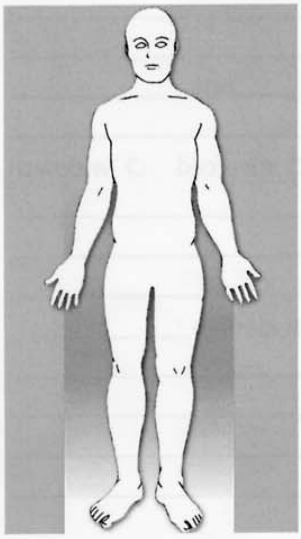
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent
❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

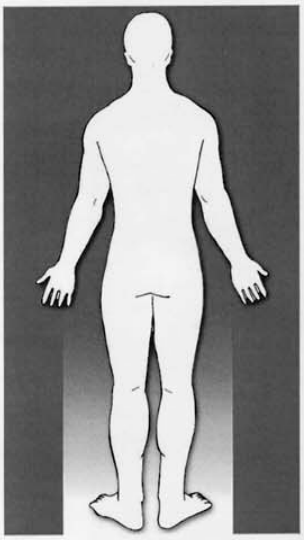
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking ❍ bending ❍ lying down ❍ weather

Please explain _____

Do you feel ❍ cramps ❍ burning ❍ other _____
❍ swelling ❍ stiffness

Do your symptoms interfere with ❍ work ❍ sleep ❍ other _____
❍ day-to-day activities ❍ play

Please explain _____

_____

On a scale of 1-10 *(1 least, 10 most)*, please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Do you have, or have you had, any of the following (*please check ✓ all that apply*)

❍ pneumonia	❍ mumps	❍ influenza	❍ rheumatic fever	❍ smallpox
❍ pleurisy	❍ polio	❍ chickenpox	❍ thyroid disease	❍ diabetes
❍ epilepsy	❍ cancer	❍ depression	❍ whooping cough	❍ anemia
❍ eczema	❍ measles	❍ arthritis	❍ heart disease	❍ rashes

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you use ❍ coffee ❍ tea ❍ artificial sweeteners ❍ sugar
❍ alcohol ❍ cigarettes ❍ recreational drugs

Have you ever suffered from (*please check ✓ all that apply*)

❍ neck pain	❍ stuffy nose	❍ discolored urine
❍ low back pain	❍ allergies	❍ gas/bloating after meals
❍ headache	❍ fainting	❍ heartburn
❍ migraines	❍ weight loss	❍ colitis
❍ arm back/tingling	❍ poor appetite	❍ irritable bowel
❍ shoulder pain	❍ excessive appetite	❍ black or bloody stools
❍ hand pain/tingling	❍ nervousness	❍ constipation
❍ leg pain/tingling	❍ confusion	❍ hemorrhoids
❍ jaw pain	❍ depression	❍ liver problems
❍ chest pain	❍ dental problems	❍ stroke
❍ lung problems	❍ excessive thirst	❍ paralysis
❍ heart problems	❍ frequent nausea	❍ tingling
❍ abnormal blood pressure	❍ vomiting	❍ numbness
❍ irregular heartbeat	❍ prostate problem	❍ fatigue
❍ ankle swelling	❍ breast pain/lump	❍ dizziness
❍ cold extremities	❍ cramps	❍ loss of sleep
❍ blurred vision	❍ painful urination	❍ difficulty hearing
❍ vision problems	❍ bladder trouble	❍ ear pain
❍ difficulty breathing	❍ excessive urination	

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check ✓ all that apply*)

❍ falls/accidents	❍ head injuries	❍ fights
❍ sports injuries	❍ broken bones	❍ dislocations
❍ spinal tap	❍ surgery	❍ traction
❍ use(d) a cane or walker	❍ extensive dental work	❍ dental appliances
❍ knocked unconscious		

If yes to any of the above, please describe _____

_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____
_____

Do you know what spinal nerve stress/ subluxation is? Yes No
If yes, please describe_____
_____

Do any friends or relatives see chiropractors? Yes No
If yes, do they use chiropractic for Health Maintenance/optimization Health problems

Are you seeking chiropractic for Health Maintenance/optimization Health problems

Are there other health concerns or anything else you'd like us to know about you? If yes, please tell us.
_____
_____

Financial Responsibility

Who is responsible for payment?_____
How will you pay for your care? (Check) (Cash) (Credit Card)
Insurance Co. _____ Group Policy #_____

Address _____ City_____ State____ Zip Code_____

Phone # (____)_____ Name of Insured _____ DOB___/___/___

Relation _____ Insured's Employer_____

<u>Office Policies</u>: If I am accepted as a patient of Dr. Marcus S. Ettinger DC, BSc I agree to pay for all services, including services not covered by my insurance company. In the event that I receive checks from my insurance company or from Third-Party insurance for services rendered at Advanced Healing Arts Institute, I understand that I am to sign the checks over to Advanced Healing Arts Institute immediately. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.
<u>Consent For X-Ray (If Needed)</u>: I authorize Advanced Healing Arts Institute to do an X-Ray examination if needed.
<u>Consent To Treat</u>: I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Ettinger to proceed with any necessary treatment.

I have read Dr. Ettinger's office policies and consent to treat information, and I agree with them by signing below:

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Marcus Ettinger

Digitally signed by Marcus Ettinger
DN: cn=Marcus Ettinger, o=CAOH.com, ou, email=askthedoctor@caoh.com, c=US
Date: 2008.07.20 21:39:23 -07'00'