Confidential Patient Information

Chiropractic Wellness Center

Dr. Simon Dove

Name: _____ E-Mail: _____

Address: _____ City, State, Zip _____

Home Ph.: _____ Cell Ph.: _____ Work Ph.: _____

May We Contact You at Work: Y N Occupation: _____ Employer: _____

Birth date: _____ Age: _____ Marital Status: S M D W

Spouse's Name: _____ Spouse's Occupation: _____

Number of Children: _____ Names & Ages of Children: _____

Whom may we thank for referring you to our office? _____

Have you ever had Chiropractic before? Y N Date: _____ Frequency: _____

FOR WOMEN: Chiropractic Care is important during pregnancy. Is there any chance you are pregnant? Y N

FOR ALL: Is the illness or injury related to an auto accident, or a Personal injury case? Y N Date/Time & Location:

Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

All charges are due when services are rendered…

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program. Please Circle the type of care that best meets your needs.

RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

CORRECTIVE CARE

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

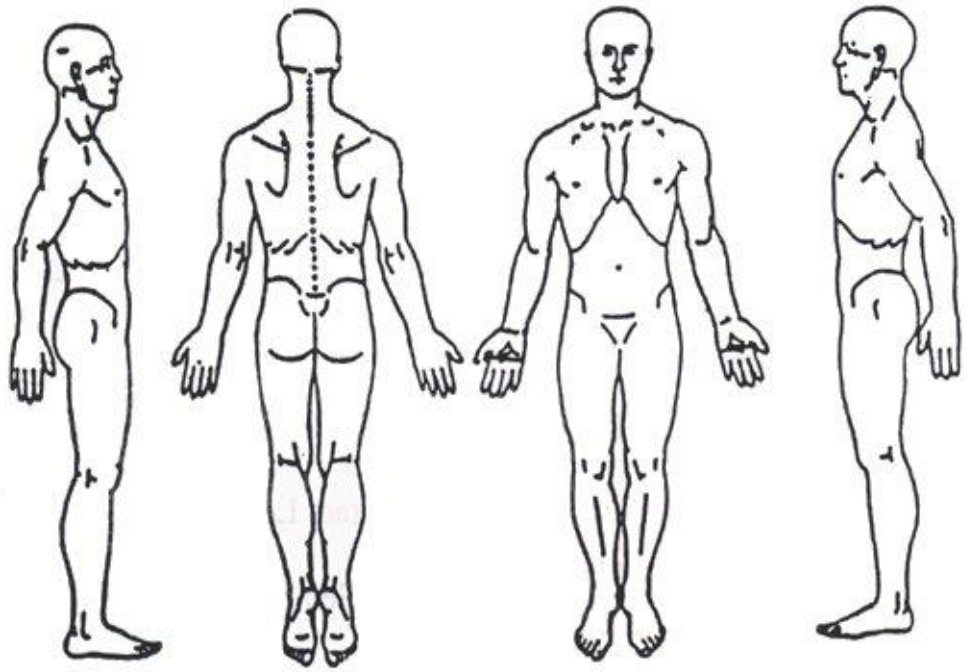
I authorize Your Chiropractic Office to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

Part I: Health Concerns/Symptoms and How They Influence Your Life

Please mark an "X" on the diagram below where your problem is:



What hurts and how long has it hurt? _____

_____

When do you think these problems originally started? _____

_____

Have you ever done anything about this concern or sought treatment for it? Y N

If yes, what were you told? _____

What was done? _____Did it seem to work? Y N

How does this impact your life? Please include: family, work, social, sleep, exercise, chores, focus & concentration, self image, self esteem, play, walking, concern about health.

_____

_____

Are you doing anything differently because of this condition/symptom/concern? _____

_____

Which best describes your current feelings about yourself and your situation?

a.) I feel helpless, like little or nothing works
b.) This is terrible, really bad. I'm scared and hope you can fix it for me.
c.) I feel stuck and can't help myself right now.
d.) I deserve more than what I have been experiencing. I would like you to assist me in my healing.
e.) Anything else?

_____

If nothing hurts: What are your health concerns?_____

Part II: Needs and Hopes for Help in This Office

Check any of the following you have had in the six months:

( ) Headaches ( ) Numbness ( ) Sinus Congestion/ Allergies ( ) Frequent Nausea/ Vomiting ( ) Vision Problems ( ) Abdominal Cramps ( ) Ear Aches ( ) Constipation ( ) Dizziness ( ) Diarrhea ( ) Heart Problems ( ) Poor / Excessive Appetite ( ) Lung Problems / Congestion ( ) Excessive Thirst ( ) Blood Pressure Problems ( ) Painful / Excessive Urine ( ) Ankle Swelling ( ) Discolored Urine ( ) Prostate/ Sexual Dysfunction ( ) Diabetes ( ) Menstrual Cycle Dysfunction ( ) Cancer

Part III: Medical, Chiropractic, and Healing History

Please list any & all past traumas or stressors you remember: For example: physical injuries, birth trauma, past illnesses, mental/emotional stressors (ex. divorce, loss of a loved one, abuse, work, relationships), exposure to chemicals, medications, and recreational drugs. Please list dates where appropriate.

_____

_____

_____

_____

_____

Please list medications (prescriptions or non prescript.) you have taken in the past 60 days.

_____

Have you had any spinal X-rays, CT scans, or MRI imaging of your spine, head, neck, back, or hips? Y N If yes, when? _____

How committed are you in improving your health?

__ Very Committed, I will do whatever it takes.

__ Somewhat committed.

__ Not Committed at all. I'm here because someone close to me wanted me to come.

Thank you for choosing our Network Care office. We are looking forward to helping you become successful in your ability to develop new ways to have a healthy spine, nervous system, and life.

Signature_____Date_____

(Parent/Guardian signature needed for pediatric patient)