

# **GITTENS CHIROPRACTIC CLINIC**

## **NEW PATIENT**

### **OUTLINE OF PROCEDURES FOR CARE**

#### **STEP ONE:**

All new patients are requested to fill out a personal health and history questionnaire.

#### **STEP TWO:**

A consultation with the doctor to discuss your health problems and to determine what may be the cause.

#### **STEP THREE:**

A comprehensive examination and evaluation including those test necessary to determine the precise cause of your problem.

#### **STEP FOUR:**

The doctor will advise you if additional laboratory test or other test including x-rays are needed.

#### **STEP FIVE:**

You will be given a Report of Findings at which the cause of your problem will be discussed. You will be given a thorough explanation of how chiropractic works and how results can be obtained. You will also be advised of office procedures and if you are accepted as a patient.

#### **STEP SIX:**

If you are accepted as a patient, chiropractic care will begin. The type of care you need will be explained to you. Also, additional explanations will be given on the types of care available at this office.

#### **STEP SEVEN:**

An estimate of the future care that is needed will be given and upon your acceptance, adjustments will begin and continue until a maximum correction for you has been obtained.

#### **STEP EIGHT:**

After maximum correction, a schedule of care will be recommended to help prevent future problems and maintain good health.

DATE

I.D. NO.

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Prov \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex: \* M \* F  
 Social Security # \_\_\_\_\_ Driver's License Number \_\_\_\_\_  
 Social Insurance \_\_\_\_\_ Circle One: Married Single Widowed Divorced Separated  
 Business Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
 Business Phone \_\_\_\_\_ Spouse's Social Security# \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Spouse's Social Insurance # \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Type of Work \_\_\_\_\_ Spouse's DOB \_\_\_\_\_  
 Referred To This Office By \_\_\_\_\_  
 Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Who Is Responsible for Your Bill, You and : \* Spouse \* Worker's Comp. \* Auto Insurance \* Medicare \* Medicaid  
 \* Personal Health Insurance (Name) \_\_\_\_\_ \* Health Card # \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Purpose of This Appointment \_\_\_\_\_  
 Other Doctors Seen For This Condition: \* Yes \* No Who? \_\_\_\_\_  
 Type of Treatment: \_\_\_\_\_ 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 of Your Accident to Your Employer: \* Yes \* No  
 Drugs You Now Take: \* Nerve Pills \* Pain killers/Muscle Relaxers \* Blood Pressure Medicine \* Insulin  
 \* Other: \_\_\_\_\_  
 Do You Wear A Shoe Lift? \* Yes \* No  
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST HEALTH HISTORY**

Please Check and Describe:

Major Surgery/Operations: \* Appendectomy \* Tonsillectomy \* Gall Bladder \* Hernia \* Back Surgery \* Broken Bones  
 \* Other: \_\_\_\_\_  
 Major Accident or Falls: \_\_\_\_\_  
 \_\_\_\_\_  
 Hospitalization (Other than Above): \_\_\_\_\_  
 \_\_\_\_\_  
 Previous Chiropractic Care: \* None \* Doctor's Name & Approximate Date of Last Visit \_\_\_\_\_

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 CONDITIONS YOU HAVE HAD:**

- |                   |                 |                    |
|-------------------|-----------------|--------------------|
| * Pneumonia       | * Mumps         | * Influenza        |
| * Rheumatic Fever | * Small Pox     | * Pleurisy         |
| * Polio           | * Chicken Pox   | * Arthritis        |
| * Tuberculosis    | * Diabetes      | * Epilepsy         |
| * Whooping Cough  | * Cancer        | * Mental Disorders |
| * Anemia          | * Heart Disease | * Eczema           |
| * Measles         | * Thyroid       | * Back Pain        |

**INTAKE**

- \* Coffee
- \* Tea
- \* Alcohol
- \* Cigarettes
- \* White Sugar

Have you been tested HIV positive? Yes No Do you take vitamins? \* Yes \* No \* Regularly \* 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

- \* Gas/Bloating After Meals
- \* Heartburn
- \* Black/Bloody Stool
- \* Colitis

**GENITO-URINARY CODE**

- \* Bladder Trouble
- \* Painful/Excessive Urination
- \* Discolored Urine

**NERVOUS SYSTEM CODE**

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

**C-V-R CODE**

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

**GENERAL CODE**

- \* Fatigue
- \* Allergies
- \* Loss of Sleep
- \* Fever
- \* Headaches

**EENT CODE**

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

**GASTRO-INTESTINAL CODE**

- \* Poor/Excessive Appetite
- \* Excessive Thirst
- \* Frequent Nausea
- \* Vomiting
- \* Diarrhea
- \* Constipation
- \* Hemorrhoids
- \* Liver Problems
- \* Gall Bladder Problems
- \* Weight Trouble
- \* Abdominal Cramps

**MALE/FEMALE**

- \* Menstrual Irregularity
- \* Menstrual Cramps
- \* Vaginal Pain/Infection
- \* Breast Pain/Lumps
- \* Prostate/Sexual Dysfunction
- \* Other Problems
- \* \_\_\_\_\_
- \* \_\_\_\_\_

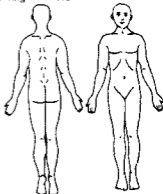
**FEMALES ONLY:**

When was your last period? \_\_\_\_\_

Are you pregnant?

- \* Yes \* No \* Not sure

Nursing \* NO \* YES



Please circle on the diagram the area of your discomfort

**FAMILY HISTORY**

Please indicate any health problems The following have:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother: \_\_\_\_\_

Sister: \_\_\_\_\_

Spouse: \_\_\_\_\_

Child: \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

CHIROPRACTIC ANALYSIS  
DIAGNOSIS:

Patient Accepted: \* Yes \* No \* Referred

Doctor's Signature \_\_\_\_\_

**WORK INFO:**

The type work you perform includes: \* Office/Clerical \* Light Labor \* Moderate Labor \* Heavy Labor

Have you been able to work since this injury? \* yes \* no

How many hours/days are in your normal work week? \_\_\_\_\_ hrs. \_\_\_\_\_ Days

While in recovery, is there any light duty work you can request? \* yes \* no

Please check your daily duties and any activities that you are occasionally asked to perform. \* Lifting \* Standing  
 \* driving \* operating equip. \* sitting \* twisting \* jumping \* climbing \* walking \* typing  
 \* work w/arms overhead \* crawling \* pulling \* bending \* stooping \* other: \_\_\_\_\_

**LEISURE**

Sedentary activities: TV/Reading/Card games/Sewing/Other \_\_\_\_\_

Strenuous activities: Exercise/Sports (type/frequency/length of time) \_\_\_\_\_

\_\_\_\_\_ Have you had to discontinue any activities? \_\_\_\_\_

Describe \_\_\_\_\_

How would you grade your general stress level?

\_\_\_\_\_ No stress \_\_\_\_\_ Minimal stress \_\_\_\_\_ Moderate stress \_\_\_\_\_ Greatly stressed

Physical activity at work

\_\_\_\_\_ Sedentary more than 50% of workday \_\_\_\_\_ light manual labor

\_\_\_\_\_ Manual labor \_\_\_\_\_ Heavy manual labor

General physical activity

\_\_\_\_\_ No regular program \_\_\_\_\_ light exercise program \_\_\_\_\_ strenuous exercise program

I hereby authorize Dr. Gittens to examine me, including X-ray if indicated by the exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings and I request all my chiropractic records to be held in strict confidence and not be given to anyone without my written consent. I clearly understand that I am totally responsible for all charges should my insurance company deny payment.

By signing your name below you certify the accuracy of your medical and/or accident history and further certify that you present to Dr. Gittens for evaluation and/or treatment of a health related condition.

*Patient's Signature:* \_\_\_\_\_ *Date* \_\_\_\_\_

**X-RAY CONFIRMATION:** This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

*Signed:* \_\_\_\_\_ *Date* \_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD:** I hereby authorize this office to administer chiropractic care as deemed necessary to my child.

*Signed* \_\_\_\_\_ (Parent/Legal guardian) *Date* \_\_\_\_\_

**I UNDERSTAND** and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directed to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

*Patient's Signature:* \_\_\_\_\_ *Date* \_\_\_\_\_

*Parent or Guardian's Signature:* \_\_\_\_\_ *Date* \_\_\_\_\_

*Information taken by:* \_\_\_\_\_ *Date* \_\_\_\_\_