

WELCOME!

PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

City/State/ZIP _____

Sex M F Age _____ Birthdate _____

Patient SS# _____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS Cell _____

Home _____ Work _____ Ext. _____

Best time and place to reach you _____

Email address: _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home phone _____ Work _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Type of accident: Auto Home Work Other

To whom have you made a report of your accident?

Auto Ins. Employer Worker's comp Other

Have you ever had chiropractic care for other problems? No Yes When? _____

Do you take Muscle Relaxers Pain Killers Insulin Birth Control Pills Over-the-counter meds
 Other prescription drugs. Please list: _____

Sleep _____ hrs/night Do you sleep on your Back Side Stomach Non-job exercise _____ hrs/week

Age of mattress _____ or waterbed _____ Is your bed comfortable? No Yes

What kind of pillow do you use? Thick Medium Thin None Support

Do you wear Heel lifts Shoe lifts Arch supports Orthotics, describe: _____

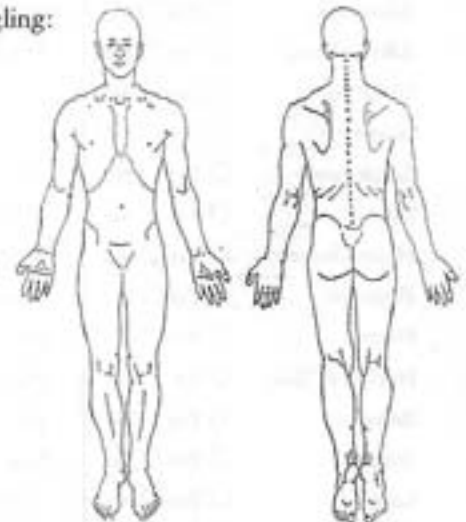
PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is condition getting progressively worse? Yes No

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Type of pain: Sharp Dull Throbbing Shooting

Aching Burning Numbness Tingling

Stiffness Swelling Cramps Other

How often do you have this pain? _____

The pain is constant comes and goes

Does it interfere with Work Daily routine

Sleep Recreation

Activities or movements that are painful to perform:

Sitting Standing Walking Bending Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for this condition: _____

Date of last: Physical Exam _____ Spinal XRay _____ Blood Test _____

Spinal Exam _____ Chest XRay _____ Urine Test _____

Dental XRay _____ MRI, CT-Scan, Bone Scan _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

AIDA/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shoes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple		Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsilitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's		Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding		Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal	
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal	
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	High		Prostate		Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping	
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical		Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	_____
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid			_____
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine		Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____

EXERCISE

None

Moderate

Daily

Heavy

WORK ACTIVITY

Sitting

Standing

Light Labor

Heavy Labor

HABITS

Smoking

Alcohol

Coffee/Caffeine drinks

High Stress Level

Packs/day _____

Drinks/week _____

Cups/day _____

Reason _____

Are you pregnant? Yes No Due Date: _____

Have you experienced the following? Please describe: _____

Date

Falls

Head Injuries

Fractures/Dislocations

Surgeries

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor responsible for any errors or omissions that I may have made in the completion of this form. Patient signature: _____ Date: _____

Name: _____

Date: _____

METABOLIC SCREENING QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

POINT SCALE: 0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Occasionally have it, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

Head Headaches Dizziness
 Fainting Insomnia Total _____

Eyes Watery or itchy eyes Swollen, red, or sticky eyelids Double vision
 Blurred vision Bags or dark circles under eyes Vision - flashes
 Tunnel vision Crossed Eyes Vision - halos
Total _____

Ears Itchy ears Earaches Ear infections
 Drainage from ear Ringing in ears Hearing loss
Total _____

Nose Stuffy nose Sinus problems Hay fever
 Sneezing attacks Excessive mucus formation Nosebleeds
Total _____

Mouth/Throat Persistent coughing Frequent need to clear throat Gagging
 Difficulty swallowing Sore throat Hoarseness
 Loss of voice Swollen or discolored tongue, gums Canker sores
 Bleeding gums Dental problems
Total _____

Skin Acne Hives Rash Dry skin Change in moles
 Flushing Hot flashes Scars Chills Excessive sweating
 Fever Itching Hair loss Change in warts Sore that won't heal
Total _____

Heart Irregular or skipped heartbeat Rapid or pounding heartbeat Chest pain
 High blood pressure Low blood pressure Varicose veins
 Swelling of ankles Total _____

Digestion Nausea Vomiting Vomiting blood Constipation
 Bloating feeling Belching Passing gas Poor appetite
 Heartburn Bowel changes Rectal bleeding Excessive hunger
 Stomach pain Indigestion Hemorrhoids Excessive thirst
 Diarrhea Total _____

Lungs Chest congestion Asthma Bronchitis
 Shortness of breath Difficulty breathing Total _____

Joints/Muscles — Please draw a line to connect effected body part to the symptom.

<input type="checkbox"/> Neck	<input type="checkbox"/> Pain or aches in joint
<input type="checkbox"/> Arms	<input type="checkbox"/> Pain or aches in muscles
<input type="checkbox"/> Hands	<input type="checkbox"/> Muscle stiffness or limitation of movement
<input type="checkbox"/> Shoulders	<input type="checkbox"/> Muscle spasms
<input type="checkbox"/> Mid back	<input type="checkbox"/> Cramps in muscles
<input type="checkbox"/> Low back	<input type="checkbox"/> Joint popping
<input type="checkbox"/> Hips	<input type="checkbox"/> Numbness
<input type="checkbox"/> Knees	<input type="checkbox"/> Pins and needles feeling
<input type="checkbox"/> Legs	<input type="checkbox"/> Feeling of weakness or tiredness
<input type="checkbox"/> Feet	<input type="checkbox"/> Arthritis

Total _____

Weight Binge eating/drinking Craving certain foods Excessive weight
 Compulsive eating Water retention Underweight
 Total _____

Energy/Activity Fatigue Sluggishness Difficulty sleeping
 Apathy Lethargy Frequent illness
 Hyperactivity Restlessness Loss of sleep
 Total _____

Mind Poor memory Forgetfulness Stuttering Poor comprehension
 Poor physical coordination Confusion Stammering Slurred speech
 Difficulty in making decisions Learning disabilities
 Total _____

Emotions Mood swings Anxiety Fear Nervousness
 Irritability Anger Depression Aggressiveness
 Total _____

Genito-Urinary Blood in Urine Lack of bladder control Frequent or urgent urination
 Genital itch or discharge
 Total _____

Men Only Breast lump Erection difficulties Lump in testicles Penis discharge
 Sore on penis Other _____
 Total _____

Women Only Abnormal pap smear Breast lump Nipple discharge Painful intercourse
 Bleeding between periods Hot flashes Vaginal discharge Extreme menstrual pain
 Date of last menstrual period _____ Are you pregnant? _____ Number of children _____
 Date of last pap smear _____ Have you had a mamogram? _____
 Total _____

Grand Total _____

TREATMENT & RELEASE FORM

I have come to Alternative Health Clinic for the following reasons:

- Nutritional Counseling** – I want to check my nutritional deficiencies and have the doctor recommended the appropriate nutritional & dietary supplements.
- Relief Care** – I am looking for only symptomatic relief of pain and discomfort.
- Corrective Care** – I am interested in having the cause of the problem as well as the symptoms corrected and relieved.
- Comprehensive Care** – I want whatever is malfunctioning in my body brought to the highest state of health possible.
- Auto Accident** – I have an accident-related injury. (Please be sure to fill out the Accident Forms.)
- Consultation** – I want the Doctor to select the type of care appropriate for my condition.

**THE PURPOSE OF OUR CLINIC IS TO SUPPORT
EACH INDIVIDUAL IN ACHIEVING THEIR
OPTIMUM HEALTH
AND TO EDUCATE THEM SO THAT THEY MAY
UNDERSTAND HEALTH AND CHIROPRACTIC
AND IN TURN EDUCATE OTHERS.**

I hereby authorize the Doctor to treat my condition as she deems appropriate through the use of manipulation throughout the spine, extremities and or nutritional consulting. The patient agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Dr. Pamela L Hart is a licensed Chiropractor with a specialty in traumatic spinal injuries, sports injuries and nutrition. She has been practicing since 1986. She does not prescribe drugs, nor does she diagnose medical conditions.

I understand that although nutritional supplements are safe, gentle, natural, and without the side effects of conventional medicine, reactions can occur. The most common, an aggravation or retracing, is a worsening of already existing symptoms, which usually lasts from several days to a few weeks. I understand that with nutrition, as with any kind of medicine, there is no guarantee of cure.

It is clear to me that if for any reason that Dr. Pamela Hart is unavailable, I will seek other care. If I have a medical emergency, I will contact my primary care physician or seek care from the local emergency room.

Patient's Name (Please Print)

Date

Patient or Guardian's Signature

ALTERNATIVE HEALTH CLINIC: FINANCIAL AND OFFICE POLICY

Thank you for choosing us as your health care provider. We are committed to bringing you the highest level of professional service. The following is our financial and office policy. By being clear now and taking care of administrative needs, we hope to avoid any unstated assumptions later on, which can interfere with the treatment process.

Since we offer a wide range of services, when scheduling an appointment, please request the type of service you desire so as to block off the appropriate amount of time: Nutrition only, Adjustment only, or both Nutrition and Adjustment. Each treatment is allotted a set of time and we wish to be respectful of your busy schedule and avoid wait times. If you think you will need more time than what is scheduled due to a sickness or new injury, please call ahead to let us know and we will do everything possible to address your needs.

CANCELLATION OF AN APPOINTMENT REQUIRES A 24-HOUR NOTIFICATION. For an appointment following a holiday or on a Monday, notice must be given on the last business day prior to the appointment. **I UNDERSTAND THAT ALL APPOINTMENTS CANCELLED LESS THAN 24-HOURS IN ADVANCE AND NO-SHOWS WILL BE CHARGED \$90.**

FEES: Fees for exams and nutritional testing are based on time, anywhere from 5 minutes to 60 minutes. Each of the following services is charged at an hourly rate:

- 1) Oral or written reports
- 2) Phone consultations, phone calls made by you to the doctor or the doctor on your behalf
- 3) Faxing and copying information on your behalf
- 4) Reading/researching materials sent to the doctor for review
- 5) Any other services performed by the doctor on your behalf

Nutritional Supplements are not returnable. They are temperature sensitive and therefore the potency can be changed or altered if left in a hot/freezing car.

Parking: please park in our driveway. If your car has an oil leak, please park directly in front of the house on the same side.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that if the Doctor's office prepares any necessary reports and forms to assist me in making collection from the insurance company, that I will be charged appropriately, and that any amount authorized to be paid directly to the Doctor's office (such as auto accident insurance check) will be credited to my account on receipt.

Personal Injury Patients: Payment for your initial treatment(s) will be expected at the time of service. Once auto insurance coverage is verified, we will submit claims on your behalf. Upon completion of treatment or end of insurance benefits, any credit on your account will be reimbursed or added to any balance owed or continued maintenance care. You are responsible for all services not covered or paid on a claim submitted to the insurance company.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. **PAYMENT IS DUE AT TIME SERVICE IS RENDERED UNLESS ARRANGEMENTS ARE MADE PRIOR TO APPOINTMENT DAY.** We accept cash, checks, MC, Visa, American Express, and Discover cards. A charge of \$22 will be added for any check returned by the bank as un-payable. All debt must be discharged before another appointment will be scheduled. 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. Any balance beyond 7 days is considered past due and subject to a billing fee of \$5.00 per week to be added to my bill until my account is current.

I acknowledge that should I not pay this account, it will automatically be turned over to a collection agency 3 months from the due date. I will be liable for any collection fee charged by the agency plus any other collection costs and any reasonable attorney fees and court costs. Further, I understand that interest will be assessed at the rate of 18% per annum on all outstanding balances.

By signing this form, I acknowledge that I have read, understand and agree to the above policy.

Patient's Signature: _____ Date: _____
Person responsible for the service fees, please sign (Parent's signature if patient under 18 years old)