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

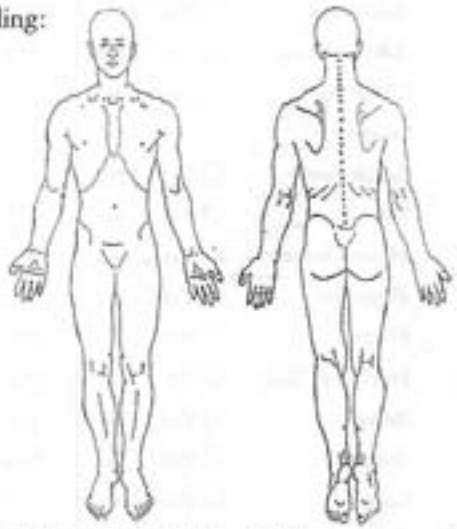
PATIENT CONDITION

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

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: _____

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	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple		Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Sclerosis	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors,Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's		Typhoid Fever	☐ Yes ☐ No
Bleeding		Hepatitis	☐ Yes ☐ No	Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Disorders	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Vaaginal	
Breast Lump	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal	
Bulimia	☐ Yes ☐ No	High		Prostate		Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Cholesterol	☐ Yes ☐ No	Problem	☐ Yes ☐ No	Whooping	
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Chemical		Liver Disease	☐ Yes ☐ No	Pschiatric Care	☐ Yes ☐ No	Other _____	
Dependancy	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatoid		_____	
Chicken Pox	☐ Yes ☐ No	Migraine		Arthritis	☐ Yes ☐ No	_____	
Diabetes	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	RheumaticFever	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/day _____
☐ Alcohol — Drinks/week _____
☐ Coffee/Caffeine drinks — Cups/day _____
☐ High Stress Level — 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
☐ Persistant 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
☐ Bloated 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.

☐ Neck	☐ Pain or aches in joint
☐ Arms	☐ Pain or aches in muscles
☐ Hands	☐ Muscle stiffness or limitation of movement
☐ Shoulders	☐ Muscle spasms
☐ Mid back	☐ Cramps in muscles
☐ Low back	☐ Joint popping
☐ Hips	☐ Numbness
☐ Knees	☐ Pins and needles feeling
☐ Legs	☐ Feeling of weakness or tiredness
☐ Feet	☐ 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 ☐ Forgetfullness ☐ 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 48-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 48-HOURS IN ADVANCE AND NO-SHOWS WILL BE CHARGED $108.**

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)