

Welcome To Our Office

Outline of Procedures for New Patients:

Step 1

All new patients are requested to fill out a confidential “**Patient Health Record**”.

Step 2

Your first “**Consultation**” with the doctor to discuss your health problems.

Step 3

You will receive a “**Chiropractic Examination**” to determine if chiropractic care is appropriate for your condition.

Step 4

You will receive an in-depth, technologically-advanced assessment of your nerve and energy system to determine how well your brain is communicating with your body. Any interference to this communication may be measured by **surface electromyography** which studies muscle function, **thermography** which illustrates inflammation and autonomic nervous system function. Other tests include **Digital Range of Motion** which measures joint function; **Algometer** which measures sensory nerve function; **Pulse wave profile** which illustrates overall health and autonomic nervous system function. A **palpation analysis** will be performed to feel taut and tender fibers and abnormal movements in the spine. As well, if indicated, **x-rays** will be taken to visualize the location of spinal problems.

Step 5

Home instruction will be provided.

Step 6

You will be advised as to a time you can return for your “**Report of Findings**” when your doctor will inform you as to your examination results and whether or not your case has been accepted. If accepted your recommended treatment program will be explained to you. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Step 7

Chiropractic care will be administered.

Step 8

Wellness Workshop: a lecture that covers the benefits of chiropractic care. Patients who attend this workshop tend to get better results, in a shorter amount of time. This workshop helps our patients reach their full potential in life and health.

Step 9

Chiropractic care will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained. Many patients then choose wellness care where chiropractic is an integral part of helping people experience health and vitality in any dimension of life.

To save time and allow us to better serve you, please complete all questions on the next pages. Thank you!

Health History Form

Name: _____ SS#: _____ - _____ - _____
Address: _____ City: _____ State: _____ Postal Code: _____
Home Phone: _____ Date of Birth: _____ Age: _____ Gender: M F
Cell Phone: _____ Email Address: _____
Marital Status: M S W D Spouse: _____ DOB: _____
Children's Name(s) and Age(s): _____
Employer: _____ Ph#: _____ Spouse's Employer: _____ Ph#: _____
Student: Yes No Who may we thank for referring you to our office? _____

Why This Form Is Important:

In this office, our focus is on helping people to function optimally so that they are stronger, healthier and better able to adapt to the stresses of everyday life. This form gives us a better understanding of the physical, chemical and emotional stresses that can gradually accumulate over time to produce health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here _____ and skip to **"Family Health History"**. Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life in the **"Current Health Concern"** section just below.

Current Health Concern

Health Concern: _____
When did you notice it? _____ How often does it occur? _____
Does it radiate? Yes No If yes, where? _____
What relieves it? _____
What aggravates it? _____
Describe how it interferes with your life, work, or hobbies: _____
Do you feel it is getting worse? Yes No If yes, how? _____
Other Professionals Seen For Concern: _____
Treatment and Results: _____

Family Health History

Please note any health issues that are present with family relations:

Children: _____
Brothers: _____
Sisters: _____
Father: _____
Mother: _____
Others: _____

In this office we will perform a thorough assessment of your spine to locate areas of **Vertebral Subluxations**. Subluxations are the areas of dysfunction in the spine that interfere with the healthy connection between the nervous system and all the different parts of your body. This will result in compromised health and reduced energy to the tissue which that part of the nervous system supplies. Subluxations are caused by *physical, chemical* and *mental/emotional* stresses that overwhelm the nervous system and spine. Please complete the next page of this form to the best of your ability. This will help us to determine the causes of the subluxations we may find.

BEACON CHIROPRACTIC

Physical Stresses

Any significant injuries or traumas during infancy that you are aware of (birth to age 5)? Yes No Unsure
Please explain: _____

Any significant falls, traumas or injuries during childhood (age 5 to 20)? Yes No Unsure
Please explain: _____

Any significant falls, traumas or injuries during adulthood? (over age 20)? Yes No Unsure
Please explain: _____

Any hospital visits for concussions, possible fractures or other traumas? Yes No Unsure

Have you had any surgeries? Yes No
If yes, please explain: _____

Any awkward or repetitive activities with work (i.e. assembly line work, on phone, etc.)? Yes No Unsure
If yes, please explain: _____

Any hobbies that are physically strenuous or require repetitive activities (i.e. hockey, golf weightlifting, etc.)?
 Yes No Unsure If yes, please explain: _____

What is your regular exercise routine? _____

Chemical Stresses

Are you currently taking any prescription medications? Yes No
If yes, which ones? _____

Do you routinely use non-prescription medications (i.e. Tylenol)? Yes No
If yes, which ones and how often? _____

Are you currently taking supplements? Yes No
If yes, which ones? _____

Do you smoke? Yes No How much? _____

Do you drink? Yes No How much? _____

Please answer the following questions regarding your diet:

Overall, how much do you eat in a day?	<input type="checkbox"/> Too little	<input type="checkbox"/> Moderate amount	<input type="checkbox"/> Too much	<input type="checkbox"/> Unsure
Daily intake of sugar?	<input type="checkbox"/> Too little	<input type="checkbox"/> Moderate amount	<input type="checkbox"/> Too much	<input type="checkbox"/> Unsure
Daily intake of caffeine?	<input type="checkbox"/> Too little	<input type="checkbox"/> Moderate amount	<input type="checkbox"/> Too much	<input type="checkbox"/> Unsure
Daily intake of fatty foods?	<input type="checkbox"/> Too little	<input type="checkbox"/> Moderate amount	<input type="checkbox"/> Too much	<input type="checkbox"/> Unsure
Daily fruits and vegetables?	<input type="checkbox"/> Too little	<input type="checkbox"/> Moderate amount	<input type="checkbox"/> Too much	<input type="checkbox"/> Unsure
Daily water intake?	<input type="checkbox"/> Too little	<input type="checkbox"/> Moderate amount	<input type="checkbox"/> Too much	<input type="checkbox"/> Unsure

Do you have any concerns about your diet and nutrition? Yes No
If yes, please explain: _____

Mental/Emotional Stresses

Since psychological stress has been shown to negatively affect nervous system function, please answer the following questions as accurately as possible. Using the scale below, grade each of the following situations in your life.

	1 – no stress	2 – a little stress	3 – moderate stress	4 – a lot of stress	5 – extreme stress
Regarding my life in general	1	2	3	4	5
Regarding my work and career	1	2	3	4	5
Regarding my relationships	1	2	3	4	5
Regarding my health and well-being	1	2	3	4	5
Regarding my finances	1	2	3	4	5
Regarding my time management skills	1	2	3	4	5

Please explain, in your own words, any areas in your life that you feel are causing you significant psychological stress:

