

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!

Adolescent Health History Form

Name: _____ SS#: _____ - _____ - _____
 Address: _____ City: _____ State: _____ Postal Code: _____
 Home Phone: _____ Date of Birth: _____ Age: _____ Gender: M F
 Cell Phone: _____ Email Address: _____
 Mother: _____ DOB: _____ Father: _____ DOB: _____
 Mother's Employer: _____ Ph#: _____ Father'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.

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:

Brothers: _____
 Sisters: _____
 Father: _____
 Mother: _____
 Grandparents: _____

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.

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 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 (i.e. computer 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

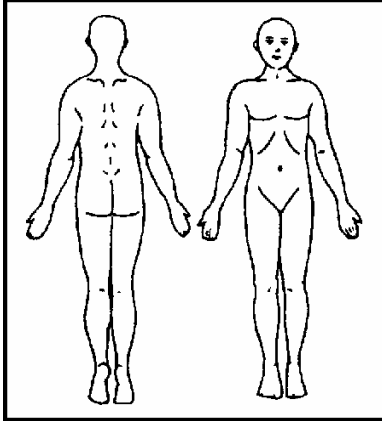
Since psychological stress has been shown to negatively affect nervous system function, please answer the following questions as accurately as possible. Using the scale below, grade each of the following situations in your life.

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:

BEACON CHIROPRACTIC



Please outline on the diagram the area of your discomfort and any radiation of pain.

- N – numbness
- P – pain
- T – tingling
- A – ache
- S – soreness
- ST – stiffness

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- Preventative Care – Life Enhancement and Wellness Care
- Corrective Care – Removing Cause and Remodeling Soft Tissue
- Relief Care – Band-Aid Care Only
- Check here if you want the doctor to select the type of care appropriate for your condition.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

signature

date

Authorization For Care of a Minor (Under 18 Years of Age)

I hereby authorize the chiropractic evaluation and care of my child by your chiropractic clinic.

Child's Name: _____ Parent's Name: _____

Parent's Signature: _____ Date: _____

Witness: _____ Date: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period _____.

signature

date