

WELCOME TO PROCARE CHIROPRACTIC CLINIC!

STEP ONE:

Welcome to our Practice!

STEP TWO:

All new arrivals fill out this personal health history questionnaire.

STEP THREE:

You'll have a quick tour of our facility.

STEP FOUR:

There'll be one-on-one education on how to improve YOUR health and well-being.

STEP FIVE:

You'll receive a special presentation about the Remarkable ProAdjuster solution.

STEP SIX:

You'll have an in-depth conversation with the doctor About your health concerns and status.

STEP SEVEN:

You'll receive a personalized report with the doctor's recommendations about improving your health.



The
Pro-Adjuster:
The Most
Advanced
Technology
In Chiropractic.



Confidential Patient Health Record

Date: _____

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip/Postal Code: _____
Home Phone: _____ Cell Phone: _____ Birth Date: _____ Age: _____ Sex: Male or Female
Social Security #: _____ E-Mail Address: _____
Employer: _____ Type of Work: _____
Employer Address: _____
Business Phone: _____
Name of Spouse: _____ Spouse's Social Security #: _____
Spouse's Employer: _____ Spouse's Work Phone _____
Spouse's Employer Address: _____
Spouse's Type of Work: _____
Name(s) and age(s) of children: _____
Who can we thank for referring you to this office? _____
Name and number of emergency contact: _____ Relationship: _____

What would you like us to do for you today? _____

Payment is expected at time service is rendered, unless other arrangements have been made.

Who is responsible for your bill, You and Spouse Workers' Comp. Auto Insurance Medicare MaineCare
 Personal Health Insurance (Name of insurance company) _____
Health Card ID # _____ Health Card Certificate # _____
Insured Person's Name _____ Insured's Birth Date: _____ Insured's SSN: _____

Name of Primary Care Physician (PCP) _____ Their location _____
Name of person who actually sees you at the PCP's office (if not the PCP) _____

CURRENT HEALTH CONDITION

Primary Unwanted Health Condition: _____
Have you seen other doctors seen for this condition? YES NO Who? _____
Type of Treatment: _____ Results: _____
Has this condition occurred before? YES NO When did this condition begin? _____
Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
Date of accident: _____ Time of accident: _____
If work-related, have you reported the accident to your employer: YES NO When? _____

Drugs you now take: Nerve pills/anti-depressants Prescription pain killers/muscle relaxers Over-the-counter pain killers/
muscle relaxers Blood pressure medicine Insulin Vitamins/supplements Other: _____

Please list any medications/vitamins you now take _____

Do you wear a shoe lift? YES NO Has one been recommended? YES NO

Do you suffer from any condition(s) other than that which you are now consulting us? YES NO

If so, what? (Please be specific) _____

PAST HEALTH HISTORY

Please check all that apply, and describe as needed:

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Neck or Back Surgery

Broken Bones Other: _____

Major Accidents or Falls (please include descriptions, dates, treatments, results of treatments): _____

Hospitalization (other than for above): _____

Previous Chiropractic Care: None Yes If yes, for what condition(s)? _____

Doctor's name, approximate date of last visit, results: _____

Has anything you've tried so far **permanently** helped you? YES NO

Has anything you've tried so far **fixed the condition(s)** you now have? YES NO

Following is a list of diseases/disorders 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 care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST:

- | | | | | |
|--|---|---|--|---------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes (type: _____) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer (type and date: _____) | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Measles (type: _____) | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Eczema | | |
| <input type="checkbox"/> Other: _____ | | | | |

Have you tested HIV positive? YES NO Is your diet high in sugar, fats, salt, carbohydrates? _____

Please check any of these you currently use, with amounts:

Coffee _____ Other caffeine _____ Alcohol _____ Cigarettes _____ White Sugar _____

Highest level of education completed _____ Diploma/degree/certificate _____

PLEASE CHECK ANY OF THE FOLLOWING YOU NOW HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- Low back pain
- Headaches
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/stiffness
- Walking problems
- Difficult chewing/clicking jaw
- General stiffness
- Tingling, numbness in _____
- Other _____

GENITO-URINARY

- Bladder trouble/infections
- Excessive urination
- Discolored urine
- Painful urination
- Problems emptying bladder
- Prostate problems
- Sexual dysfunction
- Incontinence

NERVOUS SYSTEM

- Nervous, anxious
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Balance Problems
- Other _____

GENERAL

- Fatigue
- Allergies
- Sleep Loss
- Fever
- Night Sweats
- Irritable/Moody
- Chills

OTHER PROBLEMS NOT LISTED

- _____
- _____

GASTRO-INTESTINAL

- Heartburn
- Black/Bloody Stool
- Colitis
- Vomiting
- Frequent Nausea
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Poor/Excessive Appetite
- Gall Bladder Problems
- Weight Gain
- Weight Loss
- Abdominal Pain
- Excessive Thirst
- Other _____

C-V-R

- Chest pain
- Shortness of breath
- Blood pressure problems
- Stroke
- Irregular heartbeat
- Heart structure problems
- Heart surgery
- Chronic lung congestion
- Persistent cough
- Wheezing
- Asthma
- Ankle swelling
- Varicose veins

E-E-N-T

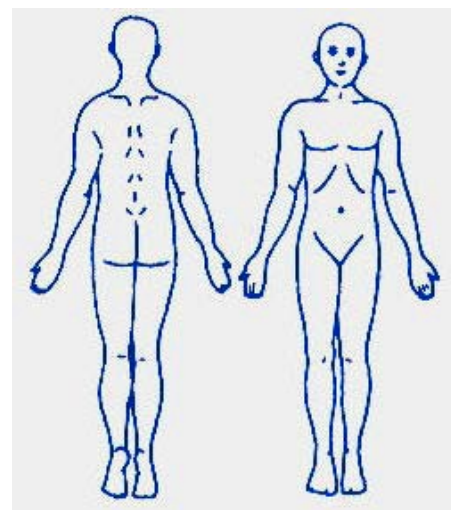
- Wearing glasses
- Dental problems
- Sore throat or hoarseness
- Earaches
- Hearing loss
- Stuffy nose
- Sinus infections
- Ringing in ears
- Loss of sense of smell
- Other _____

GENDER-RELATED

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain, infection
- Breast Pain/Lumps
- Sexual Dysfunction
- Frequent Bladder infections
- Other _____

FEMALES ONLY:

When was your last period? _____
 Are you pregnant? YES NO Not Sure
 In menopause YES NO
 Gone through menopause YES NO



Please place an X on the diagram on all area(s) of your pain or discomfort.

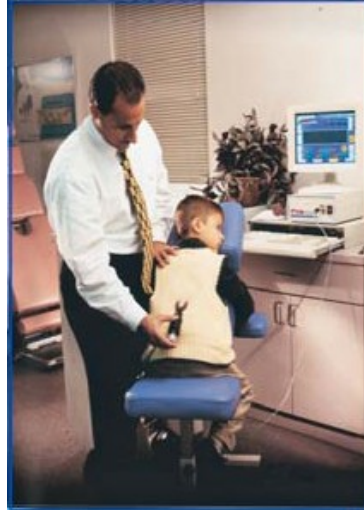
FAMILY HISTORY: If family members have or had the same or similar problem as you, please list these health problem(s) and indicate whether or not they are deceased.

- Father _____
- Mother _____
- Sister(s) _____
- Brother(s) _____
- Spouse _____
- Child (ren) _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Restorative and Rehabilitative Care). Your doctor will carefully weigh your needs and desires when recommending your treatment program.



Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of them. It's like drying a floor that has become wet from a leaky pipe, but not fixing the leak.



Restorative care differs from relief care in that its goal is not just to get rid of the symptoms or pain, but to also correct the cause of the problem and reduce the chance of a relapse. It takes longer, but its benefits are longer-lasting.

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

- Relief Care Restorative Care I'd like the doctor to select the type of care appropriate for my condition

_____ Date _____
Signature of Patient (for Care Preferences)

Patient's Name (printed)

If this is an accident-related injury, you will need to fill-out the Accident Form. Thank You !

PLEASE READ THE FOLLOWING FINANCIAL NOTICE CAREFULLY :

I, the undersigned patient, understand that health and accident insurance policies are solely an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and I accept personal responsibility for payment for services when they are rendered, regardless of insurance reimbursement, in accordance with the terms of this paragraph and any additional financial arrangements I may enter into with ProCare Chiropractic Clinic. I understand that ProCare Chiropractic Clinic operates as a cash-based practice but will, as a courtesy, perform initial insurance-coverage verification and prepare necessary reports and forms to assist in my collections from the insurance company; I understand that I am ultimately responsible for verification of coverage for services received from ProCare Chiropractic Clinic. I understand that any amounts paid directly to the Doctor's office by insurance will be credited to my account upon receipt, and that such payments will have no effect on or change in any way financial arrangements I have with ProCare Chiropractic Clinic. I also understand and accept that if I suspend or terminate care prior to the completion of my personalized course of care, any fees for professional services rendered me up to and including on that date will be immediately due and payable. I hereby authorize the Doctor to treat my condition as he deems appropriate.

Patient's Signature _____ Date: _____

Patient's Name (printed) _____

Guardian or Spouse's
 Signature Authorizing Care: _____ Date: _____

Consent to Treat a Minor

Minor's Name _____

Parent or Guardian's
 Signature Authorizing Care: _____ Date: _____

Relationship to minor patient _____