

TO THE NEW PATIENT OUTLINE OF PROCEDURES FOR CARE

Step One

All new patients are requested to fill out the personal health history questionnaire and additional paperwork.

Step Two

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

Step Three

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

Step Four

The doctor will advise you if additional laboratory tests or x-rays are needed.

Step Five

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

Step Six

If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

Step Seven

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

Step Eight

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

PERSONAL HISTORY

Name: _____	Birth Date: _____	Age: _____	Sex: M F _____
Address: _____	Social Security #: _____		
City: _____	Business Employer: _____		
State: _____	Zip Code: _____		
Home Phone: _____	Business Phone: _____		
Cell Phone: _____	Type of Work: _____		
E-mail Address: _____	Circle: Married Single Widowed Divorced Separated _____		
Referred to this office by: _____	Name of Spouse: _____		
*Would you like us to bill your health insurance: Yes No _____	Number of Children: _____		
*Would you like us to bill Medicare: Yes No _____	Emergency Contact: _____		
*Are you working with an injury attorney: Yes No _____	Relationship: _____		
	Phone Number: _____		

***For billing purposes we need a copy of your current driver's license, health insurance card, Medicare card, and/or attorney contact information.**

CURRENT HEALTH CONDITION

Current Health Concern(s): _____

Other Doctors Seen for this Condition: Yes No Who? _____

Type of Treatment: _____ Results: _____

When did this Condition Begin? _____ Has this Condition Occurred Before? Yes No

Is Condition: Job Related Auto Accident Home Injury Fall Other: _____

Date of Accident: _____ Time of Accident: _____

Have you made a report of your accident to your employer? Yes No

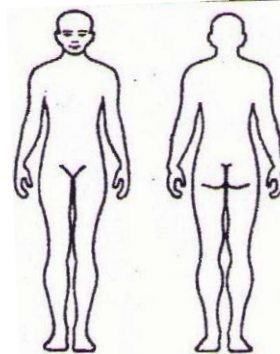
Drugs you now take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin Sleep Aids

Other: _____

Do you wear a shoe lift or orthotic inserts? Yes No

Do you suffer from any condition other than that which you are now consulting us? _____

Please outline on the diagram the area of your discomfort:



PAST HEALTH HISTORY

Major Surgery/Operations: Appendectomy Tonsillectomy Gall Bladder Hernia Back Surgery Broken Bones

Other: _____

Major Accidents or Falls: _____

Hospitalizations (Other than above): _____

Previous Chiropractic Care: None Doctor's name and approximate date of last visit _____

Below are is a list of diseases 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:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | INTAKE |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Coffee |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago | <input type="checkbox"/> White Sugar |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema | |

Have you ever tested HIV positive? Yes No

Check any of the following you have had in the past 6 months:

Musculo-skeletal

- Low back pain
- Pain between the shoulders
- Neck pain
- Arm pain
- Joint pain/stiffness
- Walking problems
- Difficult chewing/clicking jaw
- General stiffness

Gastro-intestinal

- Poor/excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall bladder problems
- Weight trouble
- Abdominal cramps
- Gas/bloating after meals
- Heartburn
- Black/bloody stool
- Colitis

Male/Female

- Menstrual irregularity
- Menstrual cramps
- Vaginal pain/infection
- Breast pain/lumps
- Prostate/sexual dysfunction
- Other problems
- _____
- _____
- _____

Nervous System

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/depression
- Fainting
- Cold/tingling extremities
- Stress

Genito-urinary

- Bladder trouble
- Painful/excessive urination
- Discolored urine

Females Only

When was your last period? _____

Are you pregnant?

- Yes No Not sure

General

- Fatigue
- Allergies
- Loss of sleep
- Fever
- Headaches

C-V-R

- Chest pain
- Short breath
- Blood pressure problems
- Irregular heartbeat
- Heart problems
- Lung problems/congestion
- Varicose veins
- Stroke

Family History

The following members have the same or a similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

EENT

- Vision problems
- Dental problems
- Sore throat
- Ear aches
- Hearing difficulty
- Stuffed nose

Relief Care: The care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak but not fixing the leak.

Corrective Care: Goal oriented care to get rid of the symptoms or pain while correcting the cause of the problem. It varies in length of time, but it is more lasting.

What kind of care do you prefer?

- Relief Care Corrective Care I want the Doctor to select the appropriate care.

Patient's Signature

Date

FINANCIAL POLICY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Life Align Wellness Center will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Life Align Wellness Center will be credited to my account on receipt. If my insurance company does not pay within a reasonable amount of time (60 days), Life Align Wellness Center reserves the right to bill me directly.

I hereby authorize Angela Cherniawski, D.C. to treat my condition as she deems appropriate. I also agree that I am personally responsible for all bills incurred at this office.

Patient/Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have reviewed and understand the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice, to request additional restrictions on the practice's use and disclosure of my personal health information, and to request additional confidential treatment of communications between the practice and myself or others.

Patient/Guardian Signature

Date

CONSENT TO EXAMINATION AND TREATMENT OF A MINOR

I am the legal guardian of (minor's name) _____ and authorize Angela Cherniawski, D.C. of Life Align Wellness Center to perform an examination and chiropractic treatment as necessary of the above minor.

Guardian's Name

Relationship to minor

Guardian's Signature

Date

Consent and Authorization to Examine and Treat

While the risks of chiropractic treatment are generally considered to be extremely low, please be aware that the following complications, though rare, may occur.

Cauda equina syndrome is usually described as the most serious accident that can result from a lumbar (low back) adjustment. It is the result of compression of the cauda equina in the lower spinal canal. The immediate effect can be a dramatic loss of bowel and bladder function. Colleagues estimate the occurrence of cauda equina syndrome from lumbar adjustments to be less than one in 100 million adjustments.

Reports of stroke and other serious complications from a cervical (neck) adjustment have appeared intermittently in the medical literature. Though no extensive research studies on this risk have been conducted, estimates have shown that the incidence of stroke from chiropractic adjustment of the neck is between one and three injuries per million adjustments.

Other risks with lumbar (low back), thoracic (mid back), and cervical (neck), and extremity adjustments that may occur, but are not limited to, are fracture, dislocation, disc rupture, strain/sprain, joint swelling, or worsening of symptoms.

I understand the risks of chiropractic care and will inquire about any of my concerns or questions regarding my examination and treatment before, during, and after care with the physician.

I also understand that if my medical condition changes, I will notify the treating physician immediately of these changes prior to continuing treatment.

Patient Signature: _____ Date: _____