"Releasing Your Inborn Power for Health and Wellness!"

Welcome to
Di Siena Family Chiropractic: Inspired Centre for Wellness

Outline of procedures of care

Step One:
All new patients are requested to fill out this personal health history questionnaire completely as possible.

Step Two:
Please read and sign all other forms.

Step Three:
A one-on-one consultation with the doctor will be done to discuss your health issues and goals, uncover the layers of past damage done and to help determine what may be the cause.

Step Four:
A comprehensive chiropractic examination and evaluation including those test necessary will be performed to further help determine the precise cause of your problem.

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

Step Six:
You will be asked to schedule a follow-up appointment called the "Wellness Orientation Workshop (W.O.W.) / Patient's Action Steps" at which time the cause of your current condition will be discussed. After reviewing your case, the doctor will decide if you will be accepted as a patient and a thorough explanation of care recommendations and *the action steps you need to take* to obtain the results you desire.

Step Seven:
Initiate care and start on your path to creating your inner wellness.

- Congratulations on taking the first steps to creating true wellness from within. ***Remember your health outcomes are based on your health choices!***

PERSONAL HISTORY

Confidential Patient Health Record

Referred by:_________________________________ Today's Date: ________-________-________

Name:____
First Middle Initial Last

Address: ____

City:_______________________________________ State:_______________ Zip code:_______________________

Home phone: [ ] ___________________________ E-mail:____

Birth date: __________-__________-_____________ Age:__________ Height:_____________Weight:____________

Sex: [ ] M [ ] F Circle one: Married Single Widowed Divorced Separated

Social security # _________-_________-___________ Driver's license #:____

Business employer:_____________________________ Type of work:____

Business phone: [ ] ________________________ Business e-mail:______________________________________

Name of spouse:________________________________ Spouse's social security #:_________-_________-___________

Spouse's employer:_____________________________ Business phone: [ ] _______________________________

Type of work:__________________________________ Business e-mail:______________________________________

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Child:_______________________ Age:_____ Have they ever been checked by a Chiropractor? [ ] Yes [ ] No

Child:_______________________ Age:_____ Have they ever been checked by a Chiropractor? [ ] Yes [ ] No

Child:_______________________ Age:_____ Have they ever been checked by a Chiropractor? [ ] Yes [ ] No

Name of emergency contact:____

Relationship:__________________________________ Phone number : [ ] _______________________________

Who is responsible for your bill? You and [ ] Spouse [ ] Workers' compensation [ ] Auto insurance [ ] Medicare

[ ] Personal health insurance (Name):____

I.D. # / Group #:____

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CHIROPRACTIC AWARENESS

- Did you know that chiropractors are actually nervous system doctors? [ ] Yes [ ] No
- Did you know that the nervous system controls all bodily functions and systems? [ ] Yes [ ] No
- Did you know that chiropractic is the largest natural healing profession in the world? [ ] Yes [ ] No
- Did you know that most spinal misalignments [subluxations] and the associated degeneration / ill health [nervous system dysfunction] that we see in our patients can begin at birth or early childhood without any associated pain? [ ] Yes [ ] No
- Did you know that regular chiropractic care could assist your body to function at a higher level of health throughout life? [ ] Yes [ ] No

PAST HISTORY OF SICKNESS / LOSS OF WELLNESS

The human body is designed to be healthy as long as there is no interference in the innate expression of your health. Throughout life, stressful events (physical, emotional and chemical) occur which damage and diminish your health expression. This case history will help uncover the layers of damage (especially to you nerve system) that have resulted in the interruption of your health expression. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Let's review some of the early years damaging events, please check all that apply and describe:

Did your mother before or during pregnancy:

[ ] Smoke [ ] Drink alcohol [ ] Use drugs [ ] On medications
[ ] Have proper nutrition [ ] Take supplements [ ] Ultrasound / dop-tones
[ ] Low back pain [ ] Experience any falls / injuries

Birth process:

[ ] Biomechanical compromise to your spine while in the mother's womb called in-utero constraint. There are various causes of in-utero constraint which include: excessive abdominal wall strength, small mother, uterine malformation, fibromata and four biomechanical compromising positions of the fetus which are: breech, face, brow and transverse. An often overlooked cause is misalignment and dysfunction of the mother's lumbar spine and pelvis which may play a role in the development of in-utero constraint by causing abnormal positions of the mother's uterus from alterations in ligament attachments and could lead to asymmetrical forces on the fetus.

[ ] Labor pains [ ] Home birth [ ] Hospital birth
[ ] Drugs:____ [ ] Antibiotics [ ] Vaccinated
[ ] Long / difficult delivery [ ] Induced labor [ ] Forceps / suction [ ] Pulling by doctor
[ ] Breech [ ] Caesarean delivery [ ] Vaginal delivery

Growth and development:

[ ] "Head banger" [ ] "Rocker"
[ ] Breast-fed until:___months [ ] Formula [ ] Solids introduced at: ~___months
[ ] Used a walker / door swing [ ] Fallen while learning how to walk
[ ] Fallen out of bed [ ] Fallen down stairs
[ ] Yanked by arms
[ ] Fallen off bike / skateboard / playground equipment / other:____
[ ] Multiple antibiotic usage
[ ] Were you taught how to care for your spine?

Additional layers of damage to your overall well-being:

Sport injuries, accidents or falls:____

Vehicular accidents:_______________________________ Work injuries:_______________________________

Major surgery / operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Tubes in the ears [ ] Spinal surgery

[ ] Broken bones [ ] Other:____

Hospitalizations (other than above):____

Drugs you **currently** take: [ ] Pain killers [ ] Muscle relaxers [ ] Blood pressure [ ]Blood thinner [ ] Insulin [ ]

Birth control [ ] Hormone replacement [ ] Other:____

Over-the-counter drugs you **currently** take: [ ] Aspirin [ ] Tylenol [ ] Advil [ ] Motrin [ ]

Other:_________________ Do you wear a heal lift / shoe lift / arch support?

Below is a list of diseases / conditions, 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 chiropractic care.

Check any of the following diseases you have or had:

[ ] Arthritis
[ ] Asthma
[ ] Atherosclerososis
[ ] Blood pressure problems
[ ] Cancer
[ ] Diabetes
[ ] Heart disease
[ ] Hemophilic
[ ] Migraines
[ ] Multiple sclerosis
[ ] Osteoporosis
[ ] Stroke / Ministroke / TIA
[ ] Lupus
[ ] Other:____

Have you ever been tested HIV positive? [ ] Yes [ ] No

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

Immune System
[ ] Allergies
[ ] Chronic infections
[ ] Chronic earaches
[ ] Chronic cough
[ ] Frequent colds / flu
[ ] Fever / Chills
[ ] Chronic fatigue

Musculo-Skeletal
[ ] Neck pain
[ ] Mid-back pain
[ ] Low back pain
[ ] General stiffness
[ ] Joint pain / Stiffness
[ ] Jaw problems
[ ] Walking problems / Foot drop

Gastro-Intestinal
[ ] Poor / Excessive appetite
[ ] Excessive thirst
[ ] Frequent nausea
[ ] Vomiting
[ ] Constipation
[ ] Diarrhea
[ ] Gas / Bloating after meals
[ ] Abdominal cramps
[ ] Weight loss / gain
[ ] Heartburn
[ ] Hemorrhoids
[ ] Black / Bloody stools
[ ] Colitis
[ ] Liver problems
[ ] Gall bladder problems

Male
[ ] Prostate problems
[ ] Sexual dysfunction

Nervous System
[ ] Headaches
[ ] Numbness / Tingling
[ ] Dizziness / Fainting
[ ] Forgetfulness
[ ] Confusion / Depression
[ ] Convulsions / Seizures
[ ] Stress / Nervous / Loss of sleep

Genito-Urinary
[ ] Discolored urine
[ ] Painful urination
[ ] Excessive urination / ↑Frequency
[ ] Urinary incontinence / Retention
[ ] Bladder / Kidney problems

Cardio-Respiratory
[ ] Chest pain
[ ] Shortness of breath
[ ] Heart problems
[ ] Irregular heartbeat
[ ] Varicose veins
[ ] Ankle swelling
[ ] Lung problems / Chronic cough
[ ] Congestion / Bronchitis

Eyes, Ears, Nose & Throat
[ ] Vision problems
[ ] Earaches
[ ] Hearing difficulty / ringing
[ ] Dizziness
[ ] Sore throat
[ ] Excessive mucus
[ ] Sinus infections
[ ] Stuffed nose

Female
Birth control pill? Yes / No
Pregnant? Yes / No / Not Sure
Last period?_______/_______/_______

Female (continued)
[ ] Sexual dysfunction
[ ] Menstrual cramps
[ ] Vaginal pain / Infection
[ ] Breast pain / Lumps
[ ] Breast implants

General (please circle and fill in blanks)
Nutrition: sugar / soda / caffeine flour / dairy / wheat / processed / fast foods / fried foods / fluorinated products
Vitamins / Supplements:______________
____
____

Exercise: Yes / No
Aerobic - How often / week:_________
Strength - How often / week:________
Stretch: - How often / week:_________

Sleep: Hours / night:_______________
on: Mattress & box spring / waterbed futon / other:__________________
Sleep on: back / stomach / side (L or R)
Use a cervical support pillow? Yes / No

Work: Prolonged: sitting / standing bending / lifting
Labor: light / heavy / computer work
Stress: work / family / physical emotional / chemical

Do you smoke? Yes / No
____ packs/day for the past _____ years

Family History
The following members have same or similar problems as I do:
[ ] Spouse [ ] Child [ ] Brother [ ] Sister [ ] Mother [ ] Father

REASON FOR SEEKING CHIROPRACTIC CARE

Patient Information Regarding Reason For Seeking Care: [ ]

Finally, the years of continued layering of damage manifest as acute or chronic symptoms.

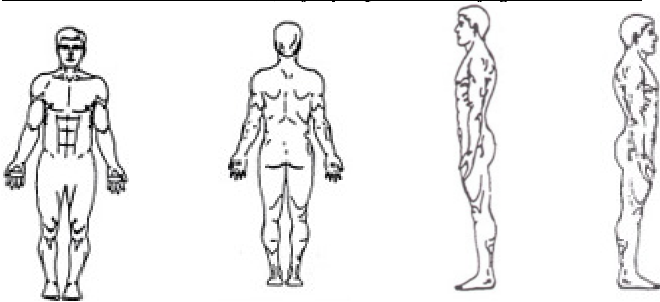
Present unwanted health condition, please describe how injury occurred? Try remembering things you did the week prior to the symptoms? (Yard work, washing car, sport activity, slept on couch,…):___________________________________

____

____

____

Please mark location(s) of symptoms on figures below:



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Injury related to: automobile accident / work injury - Have you reported your accident to your employer? [ ] Yes [ ] No

Do you ever experience any of these symptoms while working? [ ] No [ ] Yes, if yes please describe what activities at work might be causing you to experience these complaints:____

____

____

CURRENT SYMPTOMS / STATE OF ILL HEALTH / RESTRICTIONS

1. What caused the onset of symptoms? Overexertion / Strenuous position / Fall / Slip / Trip / Other:________________
2. When did first symptom appear?______________ Occurred before? [ ] Yes [ ] No How long ago?_____________
3. Is this condition getting worse? [ ] Yes [ ] No When this problem is at it's worst, how does it feel?______________

(please circle most accurate description of your complaint for numbers 4 – 9)

4. *Severity:*
   - Minimal – Annoyance – No impairment
   - Slight – Some mild impairment
   - Moderate – Marked impairment
   - Severe – Incapacitated/Bed ridden
   - 0 1 2 3 4 5 6 7 8 9 10
   - No Pain → Excruciating Pain

5. *Duration:*
   - Occasional [25% of the day]
   - Intermittent [25-50% of the day]
   - Frequent [50-75% of the day]
   - Constant [75-100% of the day]

6. *Character:*
   - Dull ache
   - Sharp / Stabbing
   - Burning
   - Throbbing
   - Radiating
   - Other:______________________

7. *Relation to other body systems:*
   - Bowel / Bladder / Numbness / Tingling
   - Muscle weakness / Dizziness / Nausea
   - Vision / Digestion / Constipation / Diarrhea
   - Breathing / Fever / Chills / Chronic Infections
   - Weight loss / Other:______________________________

8. *Relieving Factors:* Rest / Exercise / Bracing / Taping / Sitting / Standing / Lying on back / Heat / Cold Pack / Other:____

9. *Aggravating Factors:* Cough / Sneeze / Bowel movement / Lifting / Bending / Push / Pull / Driving / Lying on back / Sitting / Walking / Running / Standing / Changing body positions / Other:_______

How has this affected and/or restricted your life? Lack of energy / Stressed / Depressed / Family activities / Playing with children / Lifting / Sleep / Work / Sports / Hobbies / Household chores / Making bed / Yard work / Washing car / Reading / Driving / Carrying groceries / Sitting / Standing / Walking, etc. Explain:________________________________

Any family members with the same problem(s)?________________________________

Other chiropractor / doctor seen for this reason? [ ] Yes [ ] No Who?________________________________

Date of last visit:__________ Type of treatment:________________________________ Results:__________________

Any drugs (prescribed or over –the-counter) specifically for this complaint?________________________________

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

GOALS

What are your current health goals you want to achieve with regular chiropractic care, nutritional & fitness changes?________________________________

Chiropractic:________________________________

Nutritional:________________________________

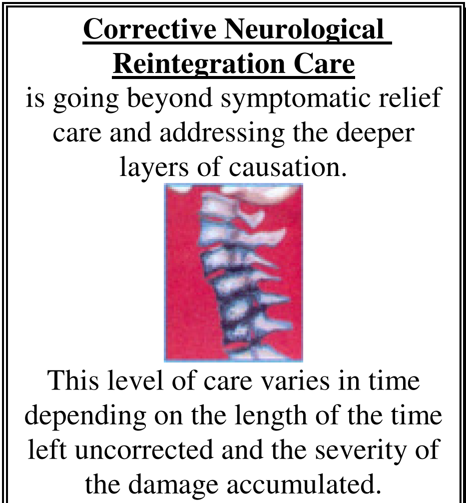
Fitness:________________________________

Why chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief care). Some are interested in having the cause of the problem corrected as well as the symptoms relieved (Corrective care). Most often patients choose to have their symptoms relieved, correction of their cause of symptoms and then maintaining their body to the highest state of health possible by using regular chiropractic care to genuinely create wellness from within (Wellness care). Your doctor will weigh your needs and desires when recommending your care program.

Symptomatic Relief Care
is the beginning phase of your care designed to provide *temporary* relief of your most current layer of symptoms.

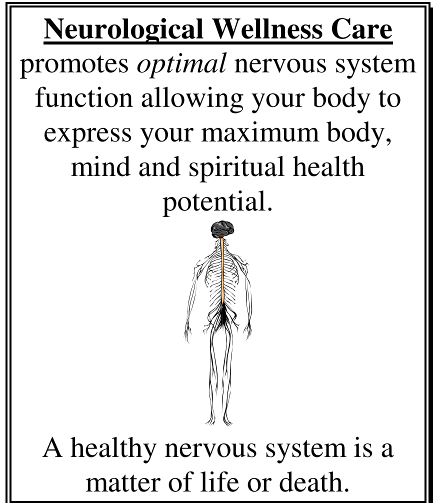
It prepares your body for the next phase of healing for optimal neurological reintegration and spinal reconstruction.

Corrective Neurological Reintegration Care
is going beyond symptomatic relief care and addressing the deeper layers of causation.



This level of care varies in time depending on the length of the time left uncorrected and the severity of the damage accumulated.

Neurological Wellness Care
promotes *optimal* nervous system function allowing your body to express your maximum body, mind and spiritual health potential.



A healthy nervous system is a matter of life or death.

Please check the type of care desired so that we may be guided by your wishes whenever possible.
[ ] Symptomatic Relief Care [ ] Corrective Neurological Reintegration Care [ ] Neurological Wellness Care
[ ] Check here if you want your doctor to select the type of care appropriate for your condition.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT (Unless other arrangements are made). We accept as payment Visa, Cash and Checks. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Some companies pay fixed allowances for certain procedures and others pay a % of the charge. It is my responsibility to pay any deductible amount, co-payment, or any other balance not paid by my insurance company. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable. A repeat billing charge of $10.00 will be added to all accounts 30 days old to defray our costs. We reserve the right to charge interest at 1 ½ % per month on balances 30 days and older. The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient or responsible party authorized by the patient to execute this agreement on behalf of the patient.

I hereby authorize the Doctor to examine, take radiographs and care for me as he or she deems appropriate through use of spinal adjustments throughout my spine. The radiographic films will remain the property of this office, being on file for seven years where they may be seen at any time while a patient of this office. The patient also 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.

Patient's Signature:____________________________________Date:____________________________________
Guardian or Spouse's

Signature of authorizing care:______________________________Date:____________________________________

Do Not Write Below This Line

Patient accepted: [ ] Yes [ ] No [ ] Refer out to / for:____

____
Doctor's signature