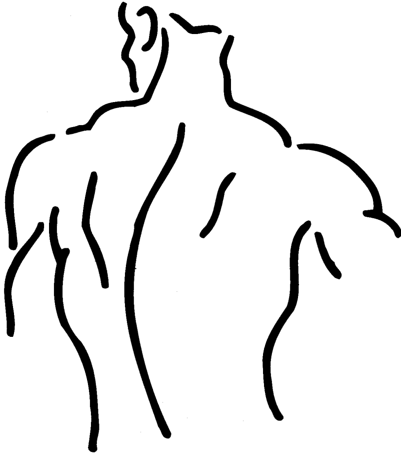
TO THE

New Patient

OUTLINE OF PROCEDURES FOR CARE



Holmes Chiropractic

Randall D. Holmes, D.C.

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(713) 862-2440
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STEP 1
All new patients are requested to fill out this personal health history questionnaire.

STEP 2
A consultation with the doctor to discuss your health problems and to determine what may be the cause.

STEP 3
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem.

STEP 4
The doctor will advise you if additional laboratory tests or other tests including x-rays are needed.

STEP 5
You will be given a Report of Findings at which time the cause of your problem will be discussed. You will be given a thorough explanation of how chiropractic works and how test results can be obtained. You will also be advised concerning how our office procedures work.

STEP 6
If you are accepted as a patient, chiropractic care will begin. The type of care you need will be explained to you. Also, additional explanations will be given on the different types of care available in the office.

STEP 7
An estimate of the future care that is needed will be given and upon your acceptance, adjustments will begin and continue until a maximum correction for you has been obtained.

STEP 8
After maximum correction, a schedule of care will be recommended to help prevent future problems and maintain good health.

CONFIDENTIAL PATIENT HEALTH RECORD

PERSONAL HISTORY

NAME			BIRTH DATE	AGE	SEX ☐ Male ☐ Female
ADDRESS			CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER		HOME PHONE	BUSINESS PHONE	
CELLULAR PHONE	PAGER		FAX	E-MAIL ADDRESS	
MARITAL STATUS ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated			NAME OF SPOUSE		
EMPLOYER NAME			SPOUSE'S EMPLOYER NAME		
TYPE OF WORK			SPOUSE'S SOCIAL SECURITY NO.	SPOUSE'S BUSINESS PHONE	
REFERRED TO THIS OFFICE BY			SPOUSE'S TYPE OF WORK		
NAMES AND AGES OF CHILDREN					
EMERGENCY CONTACT NAME	PHONE NUMBER		RELATIONSHIP		
WHO IS RESPONSIBLE FOR YOUR BILL? YOU AND ☐ SPOUSE ☐ WORKER'S COMPENSATION ☐ AUTO INSURANCE ☐ MEDICARE ☐ MEDICAID					
DO YOU HAVE PERSONAL HEALTH INSURANCE OR A HEALTH CARD? ☐ YES ☐ NO If yes, please give your personal insurance/health card to the receptionist with this form.					

CURRENT HEALTH CONDITION

REASON FOR COMING TO OUR OFFICE?	
WHAT HAVE YOU DONE FOR THIS PROBLEM SO FAR?	
WHY DO YOU THINK THAT YOU STILL HAVE THIS PROBLEM?	
WHAT IS YOUR COMMITMENT LEVEL TO CORRECTING THIS PROBLEM? ☐ HIGH ☐ MEDIUM ☐ LOW	
TO ACHIEVE OPTIMUM RESULTS ARE YOU WILLING TO DO WHAT THE DOCTOR RECOMMENDS? ☐ YES ☐ NO ☐ MAYBE	
HAVE YOU SEEN A CHIROPRACTOR BEFORE? ☐ YES ☐ NO	REASON FOR LEAVING?

PAST HEALTH HISTORY

MAJOR SURGERY/OPERATIONS ☐ APPENDECTOMY ☐ TONSILLECTOMY ☐ GALL BLADDER ☐ HERNIA ☐ BACK SURGERY ☐ BROKEN BONES
OTHER MAJOR SURGERY/OPERATIONS (please explain)
MAJOR ACCIDENTS OR FALLS
HOSPITALIZATION (other than above)

Below are 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 chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

DO YOU INTAKE?

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

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

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ 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

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ ______________________
- ☐ ______________________
- ☐ ______________________

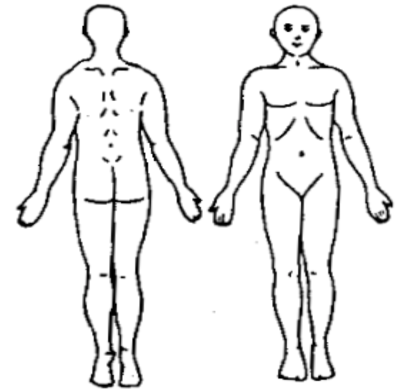
FEMALES ONLY

When was your last period?

____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort.

FAMILY HISTORY

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

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

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

____
Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go 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 (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

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

☐ **Relief Care**

Relief care is 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 we from a leak, but not fixing the leak.

☐ **Corrective Care**

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

☐ Check here if you want the doctor to select the type of care appropriate for your condition.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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 any 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 me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I also understand that any past due balance on my account is subject to a 1.5% per month service charge.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of chiropractic adjustments throughout my spine. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file 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. I understand that Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal: to locate, analyze and correct spinal interference to the nervous system.

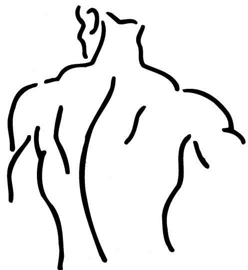
____________________________________ Patient's Signature

__________________ Date

____________________________________ Guardian/Spouse's Signature Authorizing Care

__________________ Date

If this is an accident-related injury, please fill out the Accident Form. Thank You!



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