Name: _____ Date: _____

PAPPAS CHIROPRACTIC CENTER & ASSOCIATES
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Chiropractic Physician
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TO THE NEW PATIENT

Outline of Procedure for New Patients

1. **STEP ONE:** All new patients are requested to fill out a personal health history questionnaire (enclosed).

2. **STEP TWO:** Your first consultation with a doctor to discuss your health problems.

3. **STEP THREE:** Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if chiropractic care is appropriate for your condition.

4. **STEP FOUR:** The doctor will advise you as to the need of additional procedures such as laboratory and x-ray tests, if necessary.

5. **STEP FIVE:** If your case requires immediate attention, you will receive care the first day.

6. **STEP SIX:** 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. You will also be advised concerning financial arrangements and insurance coverage as appropriate. You are encouraged to bring your spouse or a family member for this consultation.

7. **STEP SEVEN:** After you return and receive your report of findings your recommended treatment program will be explained to you.

8. **STEP EIGHT**: Upon completion of the above steps treatment will begin. Periodic reexamination will be preformed to monitor your level of improvement. Decisions about your care will be mutually decided upon by yourself and the doctor.

CONFIDENTIAL PERSONAL HISTORY

NAME _____ DATE OF BIRTH _____ MARTIAL STATUS: M S W D
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE (H) _____ (B) _____ (Cell) _____
EMPLOYED BY _____ TYPE OF WORK _____ SS# _____
SEX _____ NO. OF CHILDREN/ AGES _____
FAMILY PHYSICIAN _____ ADDRESS _____ CITY _____ STATE _____
REFERRED TO THIS OFFICE BY _____
INSURANCE ☐ MAJOR MED/ HMO ☐ WORK COMP ☐ AUTO ☐ MEDICARE ☐ CASH

PRESENT COMPLAINT(s) /OR REASON FOR YOUR VISIT _____

DATE OF ONSET _____ CAUSES (IF KNOWN) _____
WHAT IMPROVES YOUR PAIN _____
WHAT WORSENS YOUR PAIN _____
ARE YOUR SYMPTOMS GETTING WORSE: YES / NO ARE YOUR SYMPTOMS: CONSTANT / INTERMITENT
DOES THE PAIN WAKE YOU FROM SLEEP _____
DOES SNEEZING, COUGHING, OR DEFECATING EVER INCREASE THE PAIN _____
IS THIS CONDITION INTERFERING WITH YOUR ☐SLEEP ☐ WORK ☐ DAILY ROUTINE ☐ SPORTS
☐PERSONAL HABITS ☐OTHER _____
DOCTORS SEEN FOR THIS CONDITION _____ DATE LAST SEEN _____
THEIR DIAGNOSIS _____ THEIR TREATMENT _____
RESULTS OF THEIR TREATMENT _____

(LEAVE BLANK SPACES IN BOX BELOW FOR DOCTOR)

PREVIOUS CHIROPRACTIC CARE ☐ YES ☐ NO
FOR WHAT CONDITIONS _____ DATE LAST SEEN _____
HAVE YOU EVER BEEN IN AN AUTO ACCIDENT ☐YES ☐NO
IF YES, LIST ALL DATES AND INJURIES SUSTAINED _____
PLEASE LIST ALL HOSPITALIZATION _____
PLEASE LIST ALL SURGERIES _____
PLEASE LIST ANY TRAUMAS, FRACTURES, BROKEN BONES _____
LIST ALL CURRENT MEDICATIONS (including Oral Birth Control) _____
LIST ALL CURRENT OVER THE COUNTER MEDICATIONS _____
LIST PAST MEDICATIONS WHICH WERE USED ON A REGULAR BASIS _____
LIST ALL VITAMINS, FOOD SUPPLEMENTS, HERBS, ETC. _____
DATE OF LAST DOCTORS VISIT _____ ANY ABNORMALITIES _____
LIST ANY SPECIAL TESTS YOU'VE HAD (ie MRI, CATSCAN, ETC.) _____
LIST ANY SPECIALISTS YOU'VE SEEN AND REASONS WHY? _____
HAVE YOU HAVE ANY PHYCOLOGICAL OR EMOTIONAL PROBLEMS _____

Name: _____ Date: _____

PLEASE NOTE THAT THIS IS A CONFIDENTIAL HEALTH QUESTIONNAIRE.

PLEASE CHECK THE APPROPRIATE BOX.

PAST REFERS TO ANY CONDITION OR SYMPTOM YOU HAD EXPERIENCED 6 MONTHS AGO OR PRIOR. **PRESENT/ CURRENT** REFERS TO ANY CONDITION OR SYMPTOM WHICH YOU NOW HAVE, OR HAVE HAD IN THE PAST 6 MONTHS, OR KNOW TO BE A REOCCURRING CONDITION. LEAVE ANY QUESTIONS BLANK SHOULD SUCH A QUESTION NOT PERTAIN TO YOU.

PAST	PRESENT	GENERAL
☐	☐	FATIGUE
☐	☐	FEVER
☐	☐	SWEATS
☐	☐	RECURRING INFECTIONS
☐	☐	SWOLLEN BODY PART
☐	☐	CANCER/TUMORS
☐	☐	DIABETES
☐	☐	ANEMIA
☐	☐	HEART DISEASE
☐	☐	STROKE
☐	☐	UNEXPLAINED WEIGHT LOSS
☐	☐	SIGNIFICANT INFECTIONS
		NEUROLOGY
☐	☐	HEADACHES
☐	☐	MIGRAINES
☐	☐	LOSS OF CONSCIOUSNESS
☐	☐	STROKE
☐	☐	FAINTING
☐	☐	NUMBNESS (Please list where)
		_____
☐	☐	MUSCLE WEAKNESS
☐	☐	SEIZURES/EPILEPSY
☐	☐	CONVULSIONS
☐	☐	TREMORS
☐	☐	BOWEL/BLADDER DYSFUNCTION
☐	☐	DIZZINESS
☐	☐	BALANCE PROBLEMS
☐	☐	CHANGE IN PERSONALITY
☐	☐	MULTIPLE SCLEROSIS
☐	☐	MUSCLE DISEASE
☐	☐	POLIO
☐	☐	SLIPPED DISC/HERNIATION
☐	☐	PINCHED NERVE
☐	☐	CARPAL TUNNEL SYNDROME
☐	☐	HEAD TRAUMA/CONCUSSION
☐	☐	BEEN KNOCKED UNCONSCIOUS
☐	☐	VERTIGO
☐	☐	OTHER (Please list)
		MUSCLE AND JOINTS
☐	☐	ARTHRITIS
☐	☐	BURSITIS
☐	☐	LOW BACK PAIN
☐	☐	NECK PAIN
☐	☐	MIDBACK PAIN
☐	☐	ANY JOINT PAIN (Please list)
		_____
☐	☐	AUTOIMMUNE (ie LUPUS)
☐	☐	GOUT

PAST	PRESENT	MUSCLE AND JOINTS (CONTINUED)
☐	☐	POOR POSTURE
☐	☐	SCOLIOSIS
☐	☐	SWOLLEN JOINTS
☐	☐	PODIATRIC/FOOT PROBLEMS
☐	☐	RHEUMATISM
☐	☐	LYME
☐	☐	OTHER (Please list)
		GENITOURINARY
☐	☐	FREQUENT URINATION
☐	☐	INABILITY TO CONTROL KIDNEYS
☐	☐	KIDNEY STONES
☐	☐	URINARY TRACT INFECTION
☐	☐	BLOOD IN URINE/CHANGE IN COLOR
☐	☐	PAINFUL URINATION
☐	☐	OTHER (Please list)
		CARDIOVASCULAR
☐	☐	HEART DISEASE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	LOW BLOOD PRESSURE
☐	☐	CHEST PAIN/PRESSURE
☐	☐	ANGINA
☐	☐	IRREGULAR HEART BEAT
☐	☐	HEART ATTACK
☐	☐	ABNORMAL EKG TESTS
☐	☐	ABNORMAL CARDIAC TESTS
☐	☐	HARDENING OF THE ARTERIES
☐	☐	BLOOD CLOTS
☐	☐	HEART MURMUR
☐	☐	POOR CIRCULATION
☐	☐	VARICOSE VEINS
☐	☐	OTHER (Please list)
		RESPIRATORY
☐	☐	ASTHMA
☐	☐	WHEEZING
☐	☐	SHORTNESS OF BREATH
☐	☐	EMPHYSEMA
☐	☐	PLEURISY
☐	☐	CHEST PAIN
☐	☐	PNEUMONIA
☐	☐	CHRONIC COUGH
☐	☐	TUBERCULOSIS
☐	☐	SPITTING UP BLOOD
☐	☐	PRODUCING PHLEGM
☐	☐	REOCCURRING COLDS
☐	☐	SLEEP APNEA
☐	☐	SNORING
☐	☐	OTHER (Please list)

Name: _____ Date: _____

PAST	PRESENT	GASTRO INTESTINAL
☐	☐	COLITIS
☐	☐	IRRITABLE BOWEL SYNDROME
☐	☐	HEART BURN/REFLUX
☐	☐	ULCERS
☐	☐	BLOODY STOOLS
☐	☐	BLACK STOOL
☐	☐	CONSTIPATION
☐	☐	REOCCURRING DIARRHEA
☐	☐	GALL BLADDER PROBLEMS
☐	☐	HEMORRHOIDS
☐	☐	HEPATITIS
☐	☐	CHIRROSIS/LIVER DISEASE
☐	☐	JAUNDICE
☐	☐	NAUSEA
☐	☐	VOMITING
☐	☐	VOMITING BLOOD
☐	☐	APPENDICITIS
☐	☐	OTHER (Please list)

SKIN

☐	☐	ITCHING
☐	☐	RASHES
☐	☐	ECZEMA
☐	☐	PSORIASIS
☐	☐	CHANGE IN SKIN COLOR
☐	☐	CHANGE IN MOLES
☐	☐	TOO DRY/OILY
☐	☐	COLD SORES
		DATE OF LAST VISIT TO DERMATOLGIST
		_____
☐	☐	OTHER (Please list)

ALLERGY

☐	☐	ENVIRONMENT
☐	☐	FOODS (please list)
☐	☐	DRUGS (please list)

EYES, EARS, NOSE AND THROAT

☐	☐	DEAFNESS/LOSS OF HEARING
☐	☐	TINNITUS/RINGING EARS
☐	☐	ENLARGED THYROID/GOITER
☐	☐	EYE PAIN
☐	☐	CHANGE IN ABILITY TO SEE
☐	☐	GLAUCOMA
☐	☐	GUM TROUBLE
☐	☐	HOARSENESS
☐	☐	NASEL OBSTRUCTION
☐	☐	HORMONE (ENDOCRINE) ABNORMALITIES

PAST	PRESENT	EYES, EARS, NOSE, THROAT CONTIUED
☐	☐	WEARS GLASSES
☐	☐	NOSEBLEEDS
☐	☐	SINUS PROBLEMS
☐	☐	SORE THROAT
☐	☐	TONSILLITIS
☐	☐	DIFFICULTY SWALLOWING
☐	☐	DATE OF LAST VISIT TO DENTIST
		_____
☐	☐	OTHER (Please list)

☐ **FOR MEN**

☐	☐	PROSTATE PROBLEM
☐	☐	INABILITY TO COMPLETELY URINATE
☐	☐	DISCHARGE FROM PENIS
☐	☐	LUMPS/BUMPS ON TESTICLES
☐	☐	HIV/AIDS
☐	☐	SEXUALLY TRANSMITTED DISEASE
☐	☐	OTHER (Please list)

☐ **FOR WOMEN**

☐	☐	EXCESSIVE MENSTRUAL FLOW
☐	☐	VAGINAL DISCHARGE
☐	☐	IRREGULAR CYCLE
☐	☐	MISCARRIAGE
☐	☐	FIBROCYSTIC BREAST
☐	☐	LUMPS/BUMPS ON BREAST
☐	☐	HOT FLASHES
☐	☐	MENOPAUSAL SYMPTOMS
☐	☐	HIV/AIDS
☐	☐	SEXUALLY TRANSMITTED DISEASE
		DATE OF LAST MENSTRUAL CYCLE
		_____
☐	☐	ARE YOU PREGNANT? YES / NO
☐	☐	OTHER (please list)

PERSONAL HABITS

COFFEE/TEA/CAFFEINE AMOUNT
OF CUPS A DAY _____
ALCOHOL AMOUNT
OF DRINKS A DAY _____

☐	☐	ALCOHOLISM
☐	☐	SUBSTANCE USE
☐	☐	TOBACCO USE

OF PACKS A DAY _____
OF YEARS _____

GOOD	AVG	POOR	
☐	☐	☐	SLEEP
☐	☐	☐	APPETITE
☐	☐	☐	EXERCISE

ARE THERE ANY HEALTH CONDITIONS YOU FEEL ARE IMPORTANT THAT WE DID NOT ASK YOU ABOUT?

_____

FAMILY HEALTH INFORMATION (Please list below any known health problems with any family members)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

INSURANCE INFORMATION

DUE TO INDIVIDUAL TYPES OF INSURANCE POLICIES, YOUR INSURANCE POLICY MAY OR MAY NOT COVER all or part of the care provided to me in this office.

DEPENDING UPON MY INSURANCE POLICY, I ACKNOWLEDGE THAT I MAY BE RESPONSIBLE FOR A PORTION OF MEDICAL EXPENSES INCURRED BY ME IN THIS OFFICE(ie.deductibles, co-insurance, co-payments, or non covered services deemed necessary by the physician,) I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO BECOME FAMILIAR WITH THE SPECIFICS OF MY PARTICULAR INSURANCE BENEFITS (i.e., obtaining referrals when necessary, changes in insurance coverage, termination of benefits, etc.)

I understand that PAPPAS CHIROPRACTIC CENTER will prepare all required forms, pre-certifications, reports, record keeping etc. necessary to obtain reimbursement for my services.

MY SIGNATURE GRANTS ASSIGNMENT OF INSURANCE BENEFIT FOR PAYMENT MEANING THAT ALL INSURANCE PAYMENTS FOR SERVICES PROVIDED TO ME IN THIS OFFICE ARE TO BE DIRECTLY PAID TO PHYSICIAN.

Should my insurance carrier provide payment to myself instead of physician such payment shall immediately be provided to physician by myself for same amounts.

I GRANT PERMISSION FOR MY PROVIDER TO PROCEED WITH ANY APPEALS PROCESS and or ARBITRATION directed toward my insurance carrier should my insurance company deny payment for any services my physician has deemed medically necessary.

I grant permission of my physician to provide my medical records to my insurance carrier during any reimbursement, appeals or arbitration process for the above mentioned purposes.

I HAVE BEEN PROVIDED WITH A COPY OF H.I.P.AA. Health Insurance Portability and Accountability Act and agree to those conditions provided to me by that office.

PATIENT'S Name Printed _____

PATIENT or Guardian'sSignature _____ Date _____

PARENT OR GUARDIAN OF MINOR only, please complete the following information.

I AUTHORIZE Pappas Chiropractic Center and or staff to examine and or treat my child.

Name Of Child_____ DATE
SIGNATURE OF PARENT OR GUARDIAN _____

Should you have a question regarding any aspect of this form please notify staff before signing.