

# TLC Family CHIROPRACTIC

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Dear New Patient,

I would like to extend a warm welcome to you on behalf of myself and the TLC Chiropractic family. As you begin as a patient, I want to assure you that we will provide you with the optimum in care and recommendations based on current scientific standards. Once the examination procedures are completed, analyzed and correlated we will present our findings to you. In order to insure your maximum understanding of our 'report of findings' you will be given educational materials that are designed to help you understand and achieve optimal spinal health. This information may be new to you even if you have been to chiropractors in the past. It is our experience that those patients who follow our recommendations and methods usually achieve the highest measure of results.

Let's begin this health process with some basic information. Please fill out the "Patient Information" on the following pages to the best of your ability. Pay special attention to the section on "Reason for Consulting the Office".

Again, we welcome you to our office and look forward to serving your spinal health needs.

Sincerely,

-The TLC Family Chiropractic Office

Date: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ yrs Birth Date \_\_\_\_\_ Marital Status: S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lb

# Children: \_\_\_\_\_ Drivers Lic #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Spouse/Nearest Relative: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer \_\_\_\_\_ Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Present Family Doctor \_\_\_\_\_ Address \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ by Doctor \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

## **Previous Chiropractic Care?**

Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last adjustment \_\_\_\_\_ Chiropractor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Were x-rays taken? Yes \_\_\_\_\_ No \_\_\_\_\_

## **Current Medications and/or Dietary Supplements:**

What \_\_\_\_\_ Amt/Frequency \_\_\_\_\_

What \_\_\_\_\_ Amt/Frequency \_\_\_\_\_

What \_\_\_\_\_ Amt/Frequency \_\_\_\_\_

**Reason for consulting our office:**

*I have no special problem; I understand the role of chiropractic in my general health care and the importance of regular spinal check-ups.*

*I have a DISEASE/SYMPTOM (circle one) and I am interested with this specific problem; in addition I am interested in learning about my Health Potential and the role of chiropractic in improving my family's health.*

*I have a DISEASE/SYMPTOM (circle one) and I am interested in help with this problem and in learning how to prevent it in the future.*

*I have a DISEASE/SYMPTOM (circle one) and I am interested in help with this specific problem.*

Explain: \_\_\_\_\_

**List details of any early trauma:**

Your Birth: Length of labor: \_\_\_\_\_ hrs. Were you born at home \_\_\_\_\_ in the hospital \_\_\_\_\_

Drugs used during delivery? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_

Forceps/Extraction? (circle if applies) Were you c-section delivery? Yes \_\_\_\_\_ No \_\_\_\_\_

Presenting position at delivery? Breach Cephalic Cord Complications

Did/Do you play contact sports? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_

**Any Significant Falls or Accidents as a Child? Please list:**

1. \_\_\_\_\_ When? \_\_\_\_\_

2. \_\_\_\_\_ When? \_\_\_\_\_

3. \_\_\_\_\_ When? \_\_\_\_\_

**As an Adult:**

1. \_\_\_\_\_ When? \_\_\_\_\_

2. \_\_\_\_\_ When? \_\_\_\_\_

3. \_\_\_\_\_ When? \_\_\_\_\_

**List Fractures during lifetime:**

What \_\_\_\_\_ When \_\_\_\_\_

What \_\_\_\_\_ When \_\_\_\_\_

What \_\_\_\_\_ When \_\_\_\_\_

**List any surgeries during lifetime:**

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Type \_\_\_\_\_ When \_\_\_\_\_ Doctor \_\_\_\_\_

Remarks \_\_\_\_\_

**Occupational Stress:**

Repetitive physical positions: \_\_\_\_\_

Heavy/ Awkward lifting, explain: \_\_\_\_\_

Other: \_\_\_\_\_

Rate your current level of emotional stress: (LOWEST) 1 2 3 4 5 6 7 8 9 10 (HIGHEST)

Do you deal with stress easily or with difficulty? \_\_\_\_\_

**Health Overview:**

Rate overall health: (sickest) 1 2 3 4 5 6 7 8 9 10 (healthiest)  
explain \_\_\_\_\_

Describe eating habits \_\_\_\_\_

Do you exercise? \_\_\_\_\_ Type \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Type \_\_\_\_\_ Quantity \_\_\_\_\_ How long? \_\_\_\_\_

Health habits you wish to change: (explain) \_\_\_\_\_

Additional pertinent information you wish to include regarding your past or current health picture: \_\_\_\_\_

**For Women Only:**

Is there any possibility that you are currently pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last menses? \_\_\_\_\_

Pregnancy History:

Number of Pregnancies: \_\_\_\_\_ Number of Births: \_\_\_\_\_

Type: \_\_\_\_\_

**Please read the following carefully, then sign and date. Thank you!**

### **Responsibility**

*We feel it is of utmost importance that each and every person in our practice become an informed patient. For this reason, it is important that you participate in our education program so that you may receive the maximum results from your care. We will only accept your case if we feel that you have a chiropractic problem.*

*Understand as your body heals, it is crucial that you take responsibility for your condition, and to the best of your ability follow our recommendations for both office and home care.*

*If you know of any underlying conditions, deformities, etc. which may affect your care here, please tell us so that we may tailor your program accordingly. Know that we will do the utmost to help you achieve maximum results from your chiropractic care.*

### **Payment**

*Payment is due for services at the time they are rendered. Prior arrangements must be made if this is not possible. Understand that you are responsible for any and all services rendered to you by this office. Insurance policies are an arrangement between you and the insurance company, not between our office and the insurance company: therefore, we will assist you in re-imbusement, however, ultimate responsibility for payment lies with you, the patient. Any and all costs associated with collection of fees for services rendered are the patients responsibility.*

### **Terms of Acceptance**

*When a patient seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals.*

*It is not the goal or the intention of this office to treat or cure any physical, mental, or emotional ailments or to diagnose or give advice about any ailment. Chiropractic has only one goal - to correct vertebral subluxations - spinal misalignments which cause alteration of nerve function and interference to the transmission of mental impulses, resulting in a reduction in the body's innate ability to express its maximum health potential.*

*Our only goal and intention is to keep the body as free from vertebral subluxations as we can. We do this because of our absolute conviction that every human being functions better on all levels when no subluxations are present. We do not do it as a treatment for any ailment. Regardless of what the disease is called we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others.*

*To facilitate safe competent chiropractic care, we need to maintain up-to-date records of illnesses, surgeries, accident or other injuries. It is the responsibility of the patient to provide all information to update those records.*

I, \_\_\_\_\_, undertake chiropractic care in this office on the understanding of and in agreement with the above explanation.

### **Questions**

*Please feel free to ask questions - we want you to be informed. Just as in a good marriage, proper communication is an absolute necessity. Our primary concern is to help you attain your optimum health.*

### **Acknowledgment**

*I have read and understand the forgoing and agree to the terms as described.*

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian/ Spouse  
Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

**Again, Welcome to our office.**

***\*\*\*We look forward to a long and healthy relationship with you \*\*\****