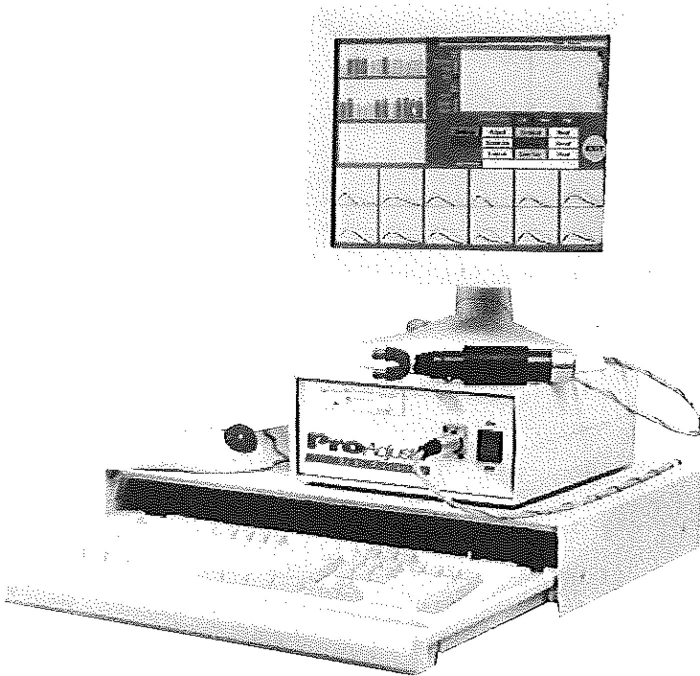
# ALTERNATIVE CHIROPRACTIC:
## A CREATING WELLNESS CENTER
**Dr. Derrick W. Denman, D.C., P.A.**

# *NEW PATIENT* INTAKE



**STEP ONE:**
*Welcome to our Practice.*

**STEP TWO:**
*All New Arrivals fill out this personal health history questionnaire.*

**STEP THREE:**
*A tour of our Facility.*

**STEP FOUR:**
*A one-on-one Education on how to improve* ***YOUR*** *health and well-being.*

**STEP FIVE:**
*A special Media Presentation about the Pro-Solution.*

**STEP SIX:**
*A one-on-one conversation with our Doctor of Chiropractic.*

**STEP SEVEN:**
*A report will be given to you about how your health can improve.*

**Dr. Derrick W. Denman** has been treating patients for more than 20 years. Dr. Denman graduated from Logan College of Chiropractic in 1988. As a chiropractor, he has chosen to serve his patients by providing holistic healthcare for the whole family. The motto of his clinic is that "Better Health is Just Around the Corner."

**Confidential Patient Health Record** **DATE:**______________

## PERSONAL HISTORY

Name: ______________ Address: ______________

City: ______________ State: ________ Zip/Postal Code: ________

Home Phone: ______________ Birth Date: ________ Age: ______ Sex: Male or Female

Social Security #: ______________ Cell Phone: ______________

E-Mail Address: ______________

Business Employer: ______________ Type of Work: ______________

Business Phone: ______________

Name of Spouse: ______________ Spouse's Social Security #: ______________

Spouse's Employer: ______________ Business Phone: ______________

Type of Work: ______________ Name and Ages of Children: ______________

Referred To This Office By: ______________ ______________

Name and Number of Emergency Contact: ______________ Relationship: ______________

Who is Responsible for Your Bill, You and ❑ Spouse ❑ Workers' Comp. ❑ Auto Insurance ❑ Medicare ❑ Medicaid

Personal Health Insurance (Name) ______________ Health Card # ______________

Insured Person's Name ______________ Date of Birth: ______________

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## CURRENT HEALTH CONDITION

Unwanted Health Condition *(why are you here today)*: ______________

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

❑ Other: ______________

Do You Wear A Shoe Lift? ❑ YES ❑ NO

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? ______________

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## PAST HEALTH HISTORY

Please Check and Describe:

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

❑ Other: ______________

Major Accidents or Falls: ______________

Hospitalization (Other than Above): ______________

Previous Chiropractic Care: ❑ None ❑ Doctor's Name & Approximate Date of Last Visit: ______________

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come 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.

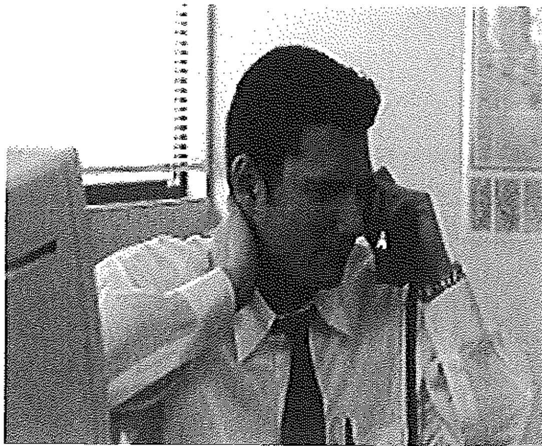
Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ❑ **Relief Care**
- ❑ **Corrective Care**
- ❑ **Check here if you want the Doctor to select the type of care appropriate for your condition**

____________________ Date

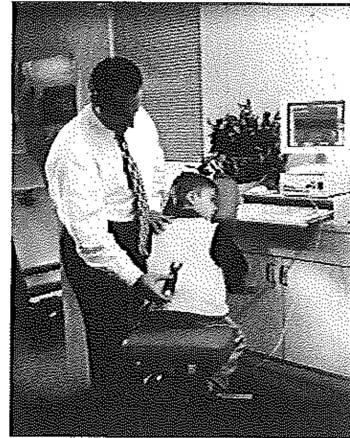
______________________________________ Patient's Signature

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



**<u>RELIEF CARE</u>**

Relief Care is that 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.



**<u>CORRECTIVE CARE</u>**

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 lasts longer.

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 upon 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 care, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. 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.

**Patient's Signature**______________________________ **Date:**__________________

**Consent to treat a Minor** ______________________________ **Date:**__________________

**Guardian or Spouse's**
**Signature of Authorizing Care:**__________________________ **Date:** __________________

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**Below 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:**

- ❑ 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

INTAKE

- ❑ Coffee
- ❑ Tea
- ❑ Alcohol
- ❑ Cigarettes
- ❑ White Sugar

Have you been tested HIV positive? ❑ YES ❑ NO

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

**MUSCULO-SKELETAL CODE**

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult 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**

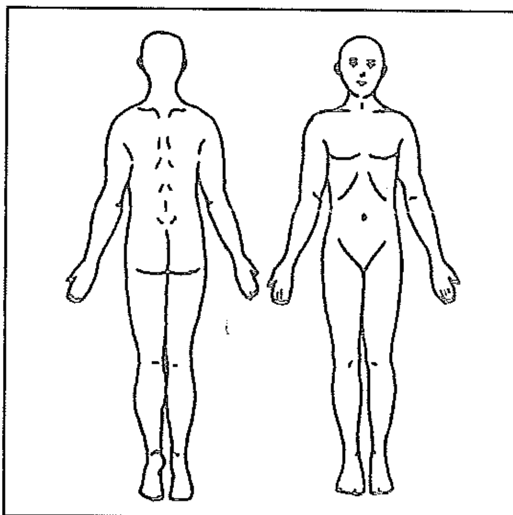
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❑ Vaginal Pain.Infection
- ❑ Breast Pain/Lumps
- ❑ Prostate/Sexual Dysfunction
- ❑ Other Problems
- ❑ ____________________
- ❑ ____________________
- ❑ ____________________

**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

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**DO NOT WRITE BELOW THIS LINE**

**ANAYLSIS:**

**DIAGNOSIS:**

**Patient Accepted:** ❑ **YES** ❑ **NO** ❑ **Referred**

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**Doctor's Signature**