TO THE New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

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

STEP FIVE:
You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

STEP SIX:
Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

STEP SEVEN:
An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: ______________________ Address: ______________________

City: ______________________ State ____________ Zip Code: ____________

Home Phone: ______________________ Birth Date: ____________ Age: ________ Sex: ☐ M ☐ F

Cell Phone: ______________________ E-mail Address: ______________________

Social Security # ______________________ Driver's License Number: ______________________

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

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 ______________________

CURRENT HEALTH CONDITION

Unwanted Health Condition ______________________

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? ______________________

____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other ______________________

Major Accident or Falls: ______________________

____

Hospitalization (Other Than Above): ______________________

____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit ______________________

Circle and describe if you have had pain or injuries to any of these areas:

Name:____________

Headaches

TMJ

Right Shoulder

Pain with movements

Injuries Surgeries Broken/fractures

Right Elbow

Pain with movements

Injuries Surgeries Broken/fractures

Right Wrist/hand

Pain with movements

Injuries Surgeries Broken/fractures

Right Hip

Pain with movements

Injuries Surgeries Broken/fractures

Right Knee

Pain with movements

Injuries Surgeries Broken/fractures

Right Ankle/Foot

Pain with movements

Injuries Surgeries Broken/fractures

Neck

Pain with movements

Injuries Surgeries

Mid Back

Pain with movements

Injuries Surgeries

Low Back

Pain with movements

Injuries Surgeries

Does pain radiate down

R L Arm(s) R L leg(s)

Left Shoulder

Pain with movements

Injuries Surgeries Broken/fractures

Left Elbow

Pain with movements

Injuries Surgeries Broken/fractures

Left Wrist/hand

Pain with movements

Injuries Surgeries Broken/fractures

Left Hip

Pain with movements

Injuries Surgeries Broken/fractures

Left Knee

Pain with movements

Injuries Surgeries Broken/fractures

Left Ankle/Foot

Pain with movements

Injuries Surgeries Broken/fractures

Indicate if pain is: (S) Sharp (A) Aching (B) Burning (N) Numbness (D) Dull (S) Shooting Pain (PN)Pins and Needles (T) Throbbing

SPINAL CORD

●Neck or Back Pain ●Weakness of Back Muscles With Walking of Standing ●Bilateral Extremity (arms or legs) Issues ●Muscle Weakness ●Disk Injury or Surgery ●Car Accidents. ●Visceral (organ) Dysfunction ●mTBI/Concussion ●Whiplash/Seatbelt Trauma. ●Stenosis Diagnosis

CEREBELLUM – SPINOCEREBELLUM

●Balance Issues ●Like To Use Handrails ●Careful on Stairs ●Scoliosis

●Sway to One Side Stand or Walk ●Prone to Falls ● Unsteady in the Dark

CEREBELLUM – CEREBROCEREBELLUM

●Terminal Tremors ●Clumsiness - Hands & Feet ● Tripping

●Decreased Tone in Limbs (weaker leg or arm) ● Increased Heart Rate ● Orthostatic Hypotension

●Possible Vertigo ●Cognitive Dysfunction

CEREBELLUM – VESTIBULOCEREBELLUM

●Dizziness ●Disorientation ●Poor Spinal Stability (sway or lean with standing/walking)

●Back Muscles Fatigue Easily ● Vertigo or Motion Sickness

●Anxiety/Dislikes Crowds ● Tinnitus ● Increased Heart Rate

●Orthostatic Hypotension

BRAINSTEM

● Visual Issues (CN 3). ● Droopy Eyelids (CN 3) ● Teeth / Gum pain (CN 5)

●Chewing food is loud (CN 5). ● Flutter or Flickering Sound in Ear (CN 5)

● Ear pain or Fullness in Ear (CN 5). ● Ear Pain when lying on it sleeping (CN 5)

● TMJ (CN 5) ● Front Headaches/ Migraines (CN 5). ● Taste Issues (CN 7/9)

●swallowing issues (CN 7). ● Hearing Issues (CN 8). ● Balance Issues (CN 7)

●Light & Sound Sensitivity. (CN 7). ● Dry mouth /Trouble Swallowing (CN 7)

●Decreased Gut Motility (CN 10) ● Any Stomach or Intestinal Conditions (CN 10) ●Heartburn (CN 10)

● Cold Hands or Feet ● one side of body Pain History ● one side of body Injury History. ●Scoliosis

●Hypertension ●High Heart Rate ●Sweat More one side of body

RECEPTORS

● Numbness or Tingling (Peripheral Neuropathy) ●Nerve Damage ● Previous Orthopedic Injuries

●Surgical Sites ●Scars ● Tattoos ● Loves Compression Gear

●Overstretch Injury ●Chronic Muscle Weakness ●Muscular Atrophy

●Joint Instability ●Nerve Pain ●Numbness or Tingling ●Skin feels different side to side on arms or legs

THALAMUS

●Chronic Pain ●Repetitive Head Trauma ● Mood Swings

● Arm or Leg Burning or Achy pain ●Scoliosis ● Loss of Multiple Sensations in Arms and Legs

●Movement Tics ●Motor Learning Deficits ●Impairment of Exec Function

●Apathy ●Problems w/Word Retrieval ● Slow Movements

●Difficulty Initiating Mvmt ● Tremors at Rest ● Cramping of Hands or Feet

OCCIPITAL LOBE

●Loss of Color Vision ●Difficulties Identifying Color ●Decreased Movt Perception

●Poor Visuospatial Processing ● Poor Eye-Hand Coordination ● Poor Eye-Foot Coordination

●Floaters ● Halos in Visual Fields ● Decreased Peripheral Awareness

●Visual Hallucinations ● headaches with reading/computer dry eyes ●eye strain ● head injuries/ concussions,

● avoid physical sports ●sound sensitivity ● sun sensitivity (need to wear glasses outside) ●blurry eye(s),

●Fluorescent lights sensitivity

INSULA

●Irritable Bowel Syndrome ●Chronic GERD (Heart Burn) ● Anxiety

●Motion Sickness ● Depression ● PTSD ●Eating Disorders

●Lack of Body Ownership ●Exercise Intolerance ●Difficulty Judging Pain Int

●Chronic Stomach Bloating ● Inappropriate Cry or Laugh ● Vertigo/Vestibular Issues

●Over awareness of Heart Beat ●Swallowing Dysfunction ●Chronic Immune Issues

●ADHD ●Pelvic Floor Dysfunction

PROACTIVE HEALTHCARE, INC
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(651) 778-0080

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Proactive Healthcare or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

______________________________	____________
Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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.

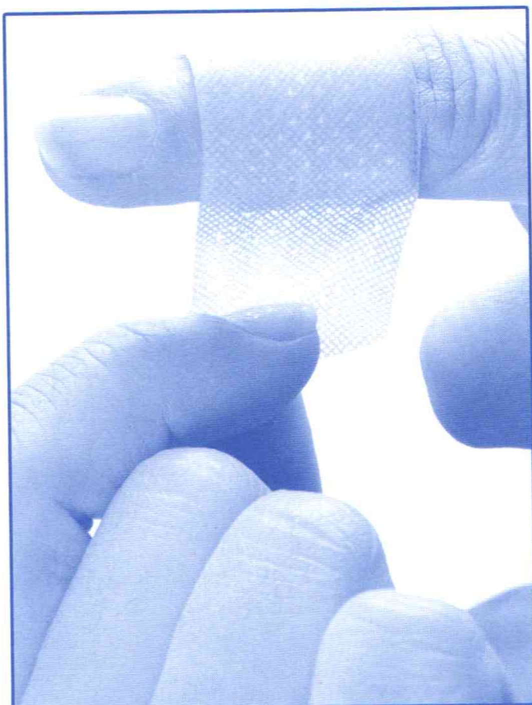
Please check the type of care desired so that we may be guided by your wishes whenever possible.

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

____________________ ______________________________________

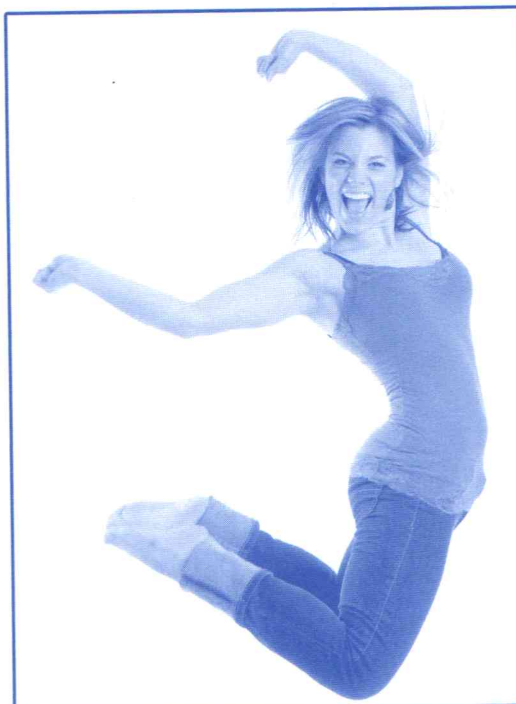
Date Patient's Signature

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



Relief Care

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.



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.

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 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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Dr. David Singer
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