

What to expect on your office visits at Neighborhood Wellness Center

Welcome to Our New Patients

On Your 1st Visit:

Allow 45 to 60 minutes.

Please fill out the enclosed forms about you and how we can help you.

This health information will be kept confidential.

You'll watch a short video that will answer questions about our special style of treatment.

You'll meet with the doctor for a consultation to discuss your health problems.

Examination - chiropractic, orthopedic, neurological tests as well as computerized spinal analysis will be done to help evaluate your condition and find the cause.

Some therapy will be provided to help you start on the road to feeling better.

Your 2nd and 3rd Visit:

Allow 20 to 30 minutes.

You'll have a private consultation with the Doctor to go over the results of your tests.

If yours is a chiropractic condition and the Doctor accepts you as a patient, then you will receive your first full chiropractic adjustment and needed therapy.

The staff will discuss any financial arrangements or any insurance benefits that you may have and they will set up your appointment schedule that the Doctor recommends.

Following Visits:

Allow approximately 10 minutes.

You'll receive your chiropractic adjustment to correct the cause of your problem along with any needed therapy to help speed the healing process.

Physical Therapy:

Therapy and Rehab exercises may be added to increase muscle strength, flexibility and to help speed your recovery. Therapies may include: Ice, Heat, Electrical Muscle Stimulation, Ultra Sound, Cold Light Laser, Traction, Massage Therapy, Nutritional Cleanse and Detox. Some may not be covered by your healthcare insurance - that doesn't mean you don't need it. Some will be done in our office and some are to be done at home between visits.

Healthcare Class:

Each month the doctor conducts informative healthcare classes. These classes are to help you get well quickly and stay that way. All new patients are to attend at least once and you may bring friends or family members. Classes are FREE. Ask about dates & Times.

Progress Examinations:

A brief progress exam will be conducted on a regular basis (approximately every 10 to 13 visits) to check your progress and to see if your treatment schedule or therapy needs to be adjusted. Allow 30 minutes.

I hope this makes you feel more comfortable, knowing what to expect from your visits with us at Neighborhood Wellness Center.

Dr. Dan Weymouth

Chiropractic Case History/Patient Information

Patient Name: _____ Date: _____ Birthdate: _____

Address: _____ City: _____ CA, Zip: _____

Home Phone: _____ Cell: _____ S. S. #: _____

Drivers Lic No. _____ **E-mail:** _____

Age: _____ Sex: _____ Status: S M W D No. of Children: _____ Work = Full Time - Part Time - Student

Name of nearest relative: _____ Phone: _____

Family Medical Doctor: _____ Phone: _____

Dr.'s Address: _____

Patient's Occupation: _____ Employer: _____

Co. Address: _____ Work Number: _____ It's OK to Call Me At Work

Purpose of this Appointment? _____

Was this caused by an: Auto Accident? _____ Work Related? _____ Date of Accident? _____

Date the symptoms appeared? _____ Days lost from work due to this problem: _____

Please check all of the following that apply:

No Yes Condition

- History of Recent Infection
- Recent Fever
- HIV / AIDS
- Diabetes
- Corticosteroids Use
- Birth Control Pills
- High Blood Pressure
- Stroke (Date)_____
- Dizziness/Fainting
- Numbness in Groin/Buttocks
- Urinary Retention
- Aortic Aneurysm
- Cancer/Tumor
- Osteoporosis
- Recent Trauma/Accidents

No Yes Condition

- Prostate Problems
- Frequent Urination
- Pregnancy, # of Births _____
- Abnormal weight Gain Loss
- Epilepsy/Seizures
- Visual Disturbances
- History of Low/Mid Back Pain
- History of Neck Pain
- Arthritis
- History of Alcohol Use
- History of Tobacco Use
- Surgery_____
- Medications;_____

Family History: Cancer Diabetes High Blood Pressure Cardiocascular Problems/Strokes

I certify that the information I have given this office is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am responsible for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature: _____ Date: _____

Additional Patient Information & Symptoms

Name: _____ Date: _____

Cell: _____ E-mail: _____

Age: _____ Height: _____ ft _____ in Weight: _____ Usual Blood Pressure: _____

Who may we thank for referring you into our office: _____

or how did you hear about us: _____

Check all present symptoms and conditions:

(Use this diagram and mark XX where the pain is)

Current Health Problem: _____

How do you feel today:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Severe Pain
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Describe the pain: Sharp Dull Numb Tingling Aching Burning

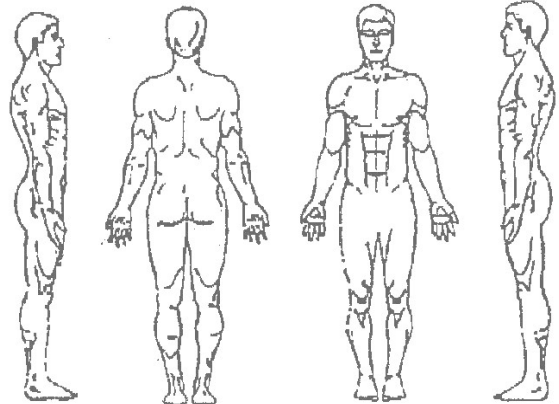
Stabbing Other _____

How often are symptoms present? 0-25% 26-50% 51-75% 76-100%

When did this begin _____ Ever had it before? _____

Can you perform daily activities? Yes No Details: _____

Medications currently on: _____



HEAD:

- Headaches
 - sinus
 - back of head
 - temples
 - migraine
- Loss of memory
- Fainting
- Blurred or Double vision
- Dizziness
- Ringing in Ears

NECK:

- Pain in the neck
- Neck pain with movement
 - forward
 - backward
 - turn to right
 - turn to left
 - bend to right
 - bend to left
- Pinched Nerve in the neck
- Neck feels out of place
- Muscle spasm
- Grinding/Popping sounds
- Arthritis in the neck

SHOULDERS:

- Pain in the shoulder joints (R - L)
- Pain across the top of the shoulders
- Bursitis (R - L)
- Arthritis (R - L)
- Can't raise arms
- Tension in shoulders
- Muscle spasm in shoulders

ARMS & HANDS:

- Pain in the upper arms
- Pain in the elbows
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Pins & Needles
- Numbness
- Fingers go to sleep
- Hands cold
- Swollen joints
- Arthritis
- Loss of grip strength

MID-BACK:

- Mid back pain
- Pain between the shoulders
- Sharp stabbing
- Dull ache
- Muscle spasm

CHEST:

- Chest Pain
- Shortness of breath
- Pain around ribs
- Breast Pain
- Pain increases when you breathe in

ABDOMEN:

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea

LOW BACK:

- Low back pain
 - Upper lumbar
 - Lower lumbar
- Pain is worse when:
 - working
 - lifting
 - stooping
 - standing
 - sitting
 - bending
 - coughing
 - lying down (sleeping)
 - walking
- Pain relieved when _____

- Disc problems

- Low back feels out of place

HIP, LEGS & FEET:

- Pain in the hip (R - L)
- Pain down the legs (R - L)
- Knee pain
- Leg cramps
- Pins & Needles
- Numbness in the feet
- Feet feel cold
- Swollen ankles or feet

GENERAL:

- Nervousness
- Depressed
- Irritable
- Fatigued
- Feel run down

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 their 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 you desire so that we may be guided by your wishes wherever possible.

Relief Care - to get rid of my symptoms or pain, but not necessarily the cause. This is the same as putting a bucket under a roof leak but not fixing the leak.

Corrective Care - with a goal of getting rid of the symptom or pain while correcting the cause of the problem. This is like replacing the roof and will take longer but is more lasting.

I want the Doctor to select the type of care appropriate for my condition

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that 10% interest is charged monthly on overdue accounts.

INFORMED CONSENT: I understand that certain risks are associated with any form of healthcare treatment and I accept that risk in order to receive treatment by the doctors and staff of Neighborhood Chiropractic and shall hold them harmless of any consequences thereof.

CONSENT TO TREAT A MINOR: I authorize the doctors and staff of Neighborhood Wellness Center to administer such procedures & treatment to _____ (minor's name) as necessary. I certify that I have the authority and responsibility to authorize treatment for this child.

PRIVACY POLICY: The patient understands and agrees to allow this chiropractic office to use their Patient Health Information only for the purpose of treatment, payment, healthcare operations, and coordination of care.

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning the privacy of those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's/Guardian's Signature _____ Date _____