



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 if 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 our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

**STEP SIX:**

If you are accepted as a patient, care will begin. Additional explanations will be given on the different types of treatments that are available in the office.

**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.

Date

I.D. NO.

**PERSONAL HISTORY 个人资料**

Name 姓名 \_\_\_\_\_ Address 住址 \_\_\_\_\_  
 City 城市 \_\_\_\_\_ State/Prov 国家/省 \_\_\_\_\_ Zip/Postal Code 邮政编码 \_\_\_\_\_  
 Home Phone 电话 \_\_\_\_\_ Birth Date 生日 \_\_\_\_\_ Age 年龄 \_\_\_\_\_ Sex 性别  M 男  F 女  
 Cell phone#手机号码 \_\_\_\_\_ Driver's license Number 驾照号码 \_\_\_\_\_  
 Social security#社会安全号码 \_\_\_\_\_ Email Address 电子信箱 \_\_\_\_\_  
 Circle One 圈选一项 Married 结婚 Single 单身 Widowed 矜寡 Divorced 离婚 Separated 分居  
 Business Employer 公司名称 \_\_\_\_\_ Type of Work 工作性质 \_\_\_\_\_  
 Business Address 公司住址 \_\_\_\_\_  
 Business Phone 公司电话 \_\_\_\_\_ Spouse's Social Security#配偶社会安全号码 \_\_\_\_\_  
 Name of Spouse 配偶姓名 \_\_\_\_\_  
 Spouse's Employer 配偶公司名称 \_\_\_\_\_ Business Phone 配偶工作电话 \_\_\_\_\_  
 Type of Work 配偶工作性质 \_\_\_\_\_ Name and ages of children 孩子名字及年龄 \_\_\_\_\_  
 Referred to This Office by 谁介绍到这里 \_\_\_\_\_  
 Name and Number of Emergency Contact 紧急联络人 \_\_\_\_\_ Relationship 关系 \_\_\_\_\_  
 Who is Responsible For Your Bill 谁付医疗费, You and  Spouse  Worker's Comp.  Auto Insurance  Medicare  
 Personal Health Insurance (Name) 个人医疗保险公司 \_\_\_\_\_  Health Card#医疗卡号 \_\_\_\_\_  
 Insured Person's Name 被保险人姓名 \_\_\_\_\_ Date Of Birth 出生日期 \_\_\_\_\_

**Current Health Condition 目前健康状况**

Unwanted Health Condition 目前有的病 \_\_\_\_\_  
 Other Doctors Seen For This Condition 有看过医生吗  Yes 是  No 否 Who? 哪位医生? \_\_\_\_\_  
 Type of Treatment 治疗型态 \_\_\_\_\_ Results 结果 \_\_\_\_\_  
 When Did This Condition Begin 何时开始的 \_\_\_\_\_ Has This Condition Occurred Before 以前是否发生过  Yes  No  
 Is Condition  Job Related 工作引起  Auto Related 车祸  Home Injury 家庭意外  Fall 跌伤  Other \_\_\_\_\_  
 Date Of Accident 意外发生日期 \_\_\_\_\_ Time of Accident 意外发生时间 \_\_\_\_\_  
 Have You Made A Report of Your Accident To Your Employer 有将意外报告公司吗?  Yes 是  No 否  
 Drugs, You Now Take 目前吃什么药  Nerve Pills 神经药物  Pain Killers/ Muscle Relaxers 止痛药/肌肉舒缓药物  Blood Pressure Medicine 治疗血压药物  Insulin 胰岛素  Other 其它 \_\_\_\_\_  
 Do You Wear A Shoe Lift 是否有穿高跟鞋  Yes 是  NO 否  
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? 目前是否有某种疾病但是您目前并没有告知我们的? \_\_\_\_\_

**PAST HEALTH HISTORY 过去病例**

Major Surgery/ Operations 手术  Appendectomy 阑尾切除  Tonsillectomy  Gall Bladder 胆囊  Hernia 疝气  Back Surgery 背部手术  Broken Bones 骨头断裂  Other 其它 \_\_\_\_\_  
 Major Accident of Falls 跌伤 \_\_\_\_\_  
 Hospitalization( Other than Above) 住院 \_\_\_\_\_

Previous Chiropractic Care 从前是否做过脊椎治疗  None 无  Doctor's Name & Approximate Date of Last Visit 若有医师姓名及最后一次看病

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problem can affect your overall course of care. 以下这些疾病可能是导致您健康问题的因素, 请仔细勾选

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Pneumonia 肺炎        | <input type="checkbox"/> Mumps 腮腺炎          | <input type="checkbox"/> Influenza 流行性感冒     | <b>Intake</b>                           |
| <input type="checkbox"/> Rheumatic Fever 风湿热 | <input type="checkbox"/> Small Pox 水痘       | <input type="checkbox"/> Pleurisy 胸膜炎        | <input type="checkbox"/> Coffee 咖啡      |
| <input type="checkbox"/> polio 小儿麻痹          | <input type="checkbox"/> Chicken Pox 水痘     | <input type="checkbox"/> Arthritis 关节炎       | <input type="checkbox"/> Tea 茶          |
| <input type="checkbox"/> Tuberculosis 结核病    | <input type="checkbox"/> Diabetes 糖尿病       | <input type="checkbox"/> Epilepsy 癫痫         | <input type="checkbox"/> Alcohol 酒      |
| <input type="checkbox"/> Whooping Cough 百日咳  | <input type="checkbox"/> Cancer 癌症          | <input type="checkbox"/> Mental Disorder 精神病 | <input type="checkbox"/> White Sugar 白糖 |
| <input type="checkbox"/> Anemia 贫血           | <input type="checkbox"/> Heart Diseases 心脏病 | <input type="checkbox"/> Lumbago 腰痛          | <input type="checkbox"/> Cigarettes 烟   |
| <input type="checkbox"/> Measles 麻疹          | <input type="checkbox"/> Thyroid 甲状腺炎       | <input type="checkbox"/> Eczema 湿疹           |   |

Have you been tested HIV positive 您曾经被检测出为 HIV 阳性反应吗?  Yes 是  No 否

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

**MUSCULO-SKELETAL CODE**

- Low Back Pain 腰痛
- Pain Between Shoulders 肩膀痛
- Neck Pain 颈部疼痛
- Arm Pain 手臂痛
- Joint Pain/Stiffness 关节痛/僵直
- Walking Problems 行走困难
- Difficult Chewing/Clicking Jaw 难吞咽
- General Stiffness 僵直
- MidBack Pain 背痛

**NERVOUS SYSTEM CODE**

- Nervous 紧张
- Numbness 麻木
- Paralysis 瘫痪无力
- Dizziness 头昏眼花
- Forgetfulness 健忘
- Confusion/Depression 困惑
- Fainting 昏厥
- Convulsions 抽搐
- Cold/Tingling Extremities 感冒
- Stress 压力

**GENERAL CODE**

- Fatigue 疲倦
- Allergies 过敏
- Loss of Sleep 失眠
- Fever 发烧
- Headaches 头痛

**GASTRO-INTESTIANL CODE**

- Poor/Excessive Appetite 没有/很大的食欲
- Excessive Thirsty 口渴
- Frequent Nausea 恶心
- Vomiting 呕吐
- Diarrhea 拉肚子
- Constipation 便秘
- Hemorrhoids 痔疮
- Liver Problems 肝病
- Gall Bladder Problems 胆囊问题
- Weight Trouble 体重问题
- Abdominal Cramps 腹绞痛

- Gas/Bloating After Meals 饭后腹胀
- Heartburn 胃灼热
- Black/Bloody Stool 大便出血
- Colitis 结肠炎

**GENTO-URINARY CODE**

- Bladder Trouble 膀胱问题
- Painful/Excessive Urination 小便疼痛
- Discolored Urine 尿变色

**C-V-R CODE**

- Chest Pain 胸口痛
- Short Breath 呼吸急促
- Blood Pressure Problems 血压问题
- Irrgular Heartbeat 心律不整
- Heart Problems 心脏问题
- Lung Problems/Congestion 肺
- Varicose Vein 静脉曲张
- Ankle Swellings 足部水肿
- Stroke 中风

**EENT CODE**

- Vision Problem 视力问题
- Dental Problems 牙齿问题
- Sore Throat 喉咙痛
- Ear Aches 耳朵痛
- Hearing Difficulty 听力困难
- Stuffed Nose 鼻塞

**MALE/FEMALE CODE**

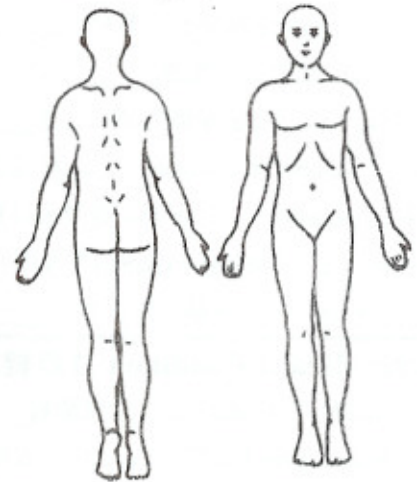
- Menstrual Irregularity 月经不正常
- Menstrual Cramps 月经疼痛
- Vaginal Pain/Infection 阴道疼痛/感染
- Breast Pain/Lumps 乳房疼痛/肿块
- Prostate 前列腺/Sexual Dysfunction 性功能不正常
- Other Problems 其它问题
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FEMALES ONLY:**

When was your last period?最近生理期\_\_

Are you Pregnant 是否怀孕

Yes 是  No 否  Not Sure 不确定



Please outline on the diagram

Area of your discomfort

请在图上圈出你不舒服的部位

**FAMILY HISTORY 遗传疾病**

The following members have the same or similar problem as I do

- Mother 母亲
- Father 父亲
- Brother 兄弟
- Sister 姐妹
- Spouse 配偶
- children 小孩

**DO NOT WRITE BELOW THIS LINE 以下请勿填写**

ANALYSIS:

DIAGNOSIS: \_\_\_\_\_

Patient Accepted:  Yes  No  Referred

Doctor's Signature \_\_\_\_\_

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.

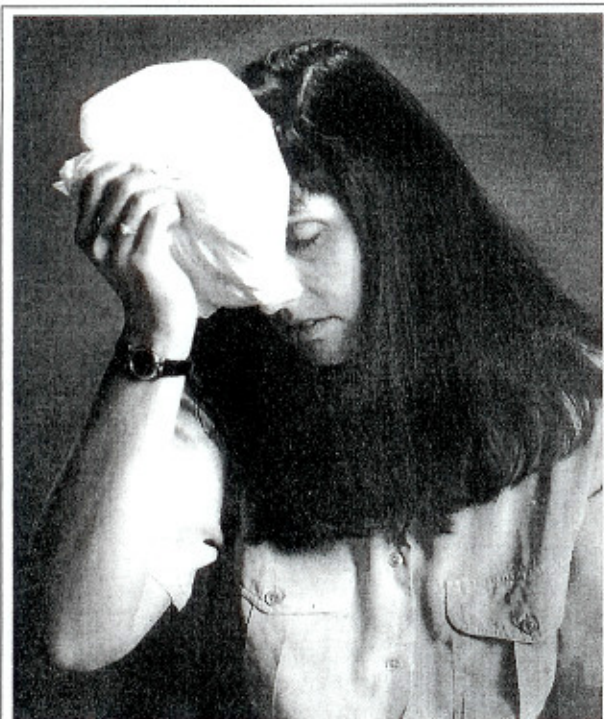
Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief Care 去痛疗法    
  Corrective Care 根治疗法    
  Check here if you want the Doctor to select the type of care appropriate for your condition  
 如果您希望由医师决定请勾选这里

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 \_\_\_\_\_