Nazareth CHIROPRACTIC

www.nazchiro.com

JEFFREY G.WACK, D.C.

WELCOME TO NAZARETH CHIROPRACTIC

Please read and complete the questionnaire on the following pages and sign the 'Terms of Acceptance' on the back page. If any areas do not apply to you, simply enter 'N/A' in the space. This information is very important and will help us to get you back on the road to better health as quickly as possible.

Your first visit will include the following:

1) **Consultation with Dr. Wack to review your personal history questionnaire and discuss your current condition or health status.**

2) **Chiropractic examination/evaluation.**

3) **Chiropractic x-ray evaluation (if necessary)**

4) **Specific spinal adjustment(s) in appropriate areas as determined from examination findings.**

On your second visit we will be reviewing your examination findings and providing you with our recommendations for achieving the maximum benefits from your chiropractic care.

FEES: Our office visit fee is $25.00. X-rays(if necessary) are additional. Payment for ALL services is due at the time that services are rendered. We do not participate or communicate with any insurance companies, but we will be happy to print out any account information for you to submit to your insurance provider or your accountant for tax purposes.

PAYMENT: Payment is accepted in the form of cash, check or credit card. We prefer that you pay by cash or check as there is no fee assessed to our office, but welcome your credit cards if you prefer that method. Advance payments can be made to your account if you prefer to not make a payment at each office visit and our software can easily and accurately keep track of your credit.

206 East Lawn Road • Nazareth, PA 18064 PH: 610-746-4949 FAX: 610-746-4968

Confidential Patient Health Record

PERSONAL HISTORY

Name:_____ Address: _____

City: _____ State _____ Zip Code: _____ E-Mail: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ❑ M ❑ F

Business Phone: _____ Circle One: Married Single Widowed Divorced Separated No. of Children____

Business/Employer:_____ Type of Work: _____

Name of Spouse:_____ Spouse's Employer: _____

Business Phone: _____ Type of Work: _____

Name and Number of Emergency Contact: _____ Relationship: _____

Referred To This Office By: _____

Who Is Responsible For Your Bill, You and ❑ Spouse ❑ Insurance ❑ Workers' Comp. ❑ Personal Injury

CURRENT HEALTH CONDITION

Purpose of This Appointment _____

_____

_____

Other Doctors Seen For This Condition: ❑ Yes ❑ No Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occured 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 any Major Surgery/Operations:

❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia ❑ Back Surgery ❑ Heart

❑ Other _____

❑ Broken Bones (description)_____

Major Accidents or Falls: _____

_____

Hospitalization (Other Than Above):_____

_____

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

_____

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 problems can affect your overall course of chiropractic 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
- ❑ Hypoglycemia
- ❑ Eczema

INTAKE

- ❑ Coffee _____ cups/day
- ❑ Tea _____ cups/day
- ❑ Alcohol
- ❑ Cigarettes ___ packs/day
- ❑ White Sugar

Have you been tested HIV positive? ❑ Yes ❑ No

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

MUSCULO-SKELETAL

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain ___R ___L ___Both
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult Chewing/Clicking Jaw
- ❑ General Stiffness
- ❑ Hip Pain ___R ___L ___Both
- ❑ Leg Pain ___R ___L ___Both
- ❑ Knee Pain ___R ___L ___Both

NERVOUS SYSTEM

- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

GENERAL

- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep _____ Hrs./Night
- ❑ Fever
- ❑ Headaches
  How Often? _____

GASTRO-INTESTINAL

- ❑ Poor/Excessive Appetive
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble ___Loss ___Gain
- ❑ Abdominal Cramps
- ❑ Gas/Bloating After Meals
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis

GENITO-URINARY

- ❑ Bladder Trouble
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

C-V-R

- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

EENT

- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches/Ringing in Ears
- ❑ Hearing Difficulty
- ❑ Stuffed Nose/Sinus Problems

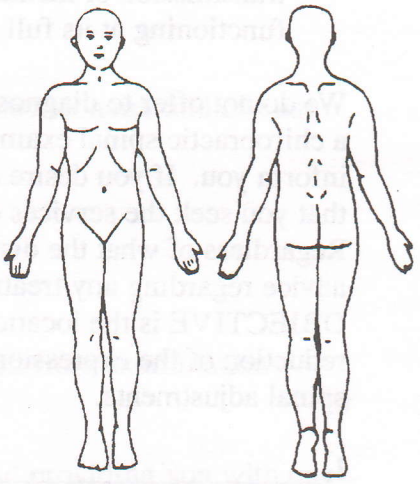
MALE/FEMALE

- ❑ 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 place an (X) on the diagram in the area(s) of your discomfort.

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ❑ Mother
- ❑ Father
- ❑ Brother
- ❑ Sister
- ❑ Spouse
- ❑ Child

TERMS OF ACCEPTANCE

When a person seeks chiropractic healthcare and we accept a person for such care, it is essential that both parties be working toward the same objective.

Chiropractic has only ONE objective. It is important that each patient understand both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment by either party.

- ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method of correction is specific spinal adjustments.
- HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
- VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebrae of the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses from the brain. The result is a body that is not functioning at its full potential and cannot properly heal or maintain itself.

We do not offer to diagnose or treat any disease or condition. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that field of healthcare. Regardless of what the disease or condition is called, we do not offer to treat it nor do we offer advice regarding any treatment prescribed by another healthcare provider. OUR ONLY OBJECTIVE is the location and correction of vertebral subluxation which results in the reduction of the expression of life in the body. Our ONLY method of treatment is specific spinal adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care and my financial responsibilities for today and future office visits in this office have been answered to my complete satisfaction.

I therefore choose to receive chiropractic care at Nazareth Chiropractic on these terms.

_____ _____
(signature) (date)