

TO THE New Patient

OUTLINE OF PROCEDURES FOR CARE

ADVANCED BODY DYNAMICS, LLC

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 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.

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Patient Intake Form

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment

Name: _____ **Date:** _____

Date of Birth: _____ Male Female

Address: _____ **Marital status:**
S M W D SEP

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Cell Provider:** _____

E-mail: _____

Occupation: _____

Referred by: _____

Emergency Contact Name: _____

Phone #: _____ **Relation:** _____

Mark (c) for current problems, check and indicate the age when you had any of the following:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Genitourinary

- Bed-wetting
- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Pus in urine
- Stress incontinence
- Urination
- Overnight more than twice
- More than 8x in 24 hrs
- Decreased flow / force
- Painful urination
- Urgency to urinate

Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

Menstrual flow

- Reg. Irreg. Pain / cramps
- Days of flow: _____ Length of cycle: _____
- Date - 1st day last period _____
- Are you pregnant? Yes No
- If yes, how many months? _____
- How many children do you have? _____
- Birth control method: _____
- Date of last PAP test: _____
 - normal abnormal
- Date of last mamogram: _____
 - normal abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV / AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness / tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medications you are currently taking and why:

Give a brief detailed description of the problem you are currently experiencing: _____

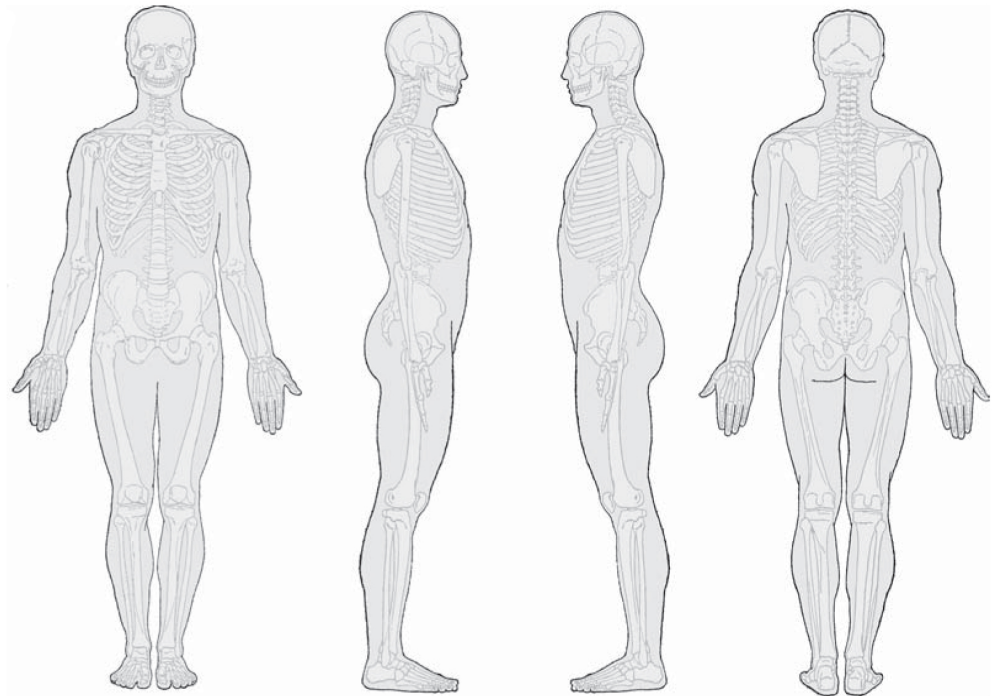
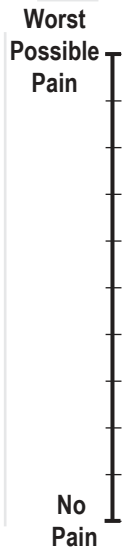
How long have you had this condition? _____ Is it getting worse? Yes No _____

Does it bother you (check appropriate box): work sleep other: _____

What seemed to be the initial cause: _____

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:



Past health history:

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... had any strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
... ever used orthotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> other			_____
How old is your mattress?			_____
When was your last physical exam?			_____

Habits	none	light	mod.	heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history: If any blood relative has had any of the following conditions, please check and indicate which relative(s)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Do you have any other health issues or concerns that our staff should be made aware of? _____

CONSENT TO TREATMENT:

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment
- b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

- a. The condition that the treatment is to address
- b. The nature of the treatment
- c. The risks and benefits of that treatment
- d. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Kelly Shockley, DC, PC and Advanced Body Dynamics, LLC.

Dated _____

Print Patients Name:

Print Witness Name:

Patient signature (or Legal Guardian)

Date:

Signature of Witness

Date: