CHIROPRACTIC

Bringing Out The Best In You

Patient _____

Doctor _____

Date _____ *Case #* _____

○ New Patient

Welcome To Our Office

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Is it okay to contact you at work? ○ no ○ yes Work # _____

E-mail address _____ Web site _____

SS# _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Marital status ○ single ○ married ○ separated ○ divorced ○ widowed

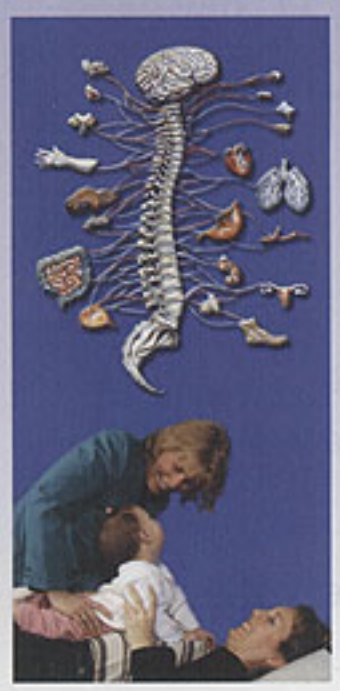
Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

Do you have any pets? ○ no ○ yes If yes, please tell us what kind(s) _____

_____



Emergency contact: Name _____

Relationship _____ Phone #(s) _____

Favorite hobbies or interests _____

What Brings You Here?

Have you ever had chiropractic care before? ○ no ○ yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? ○ no ○ yes

How did you find out about our office? _____

Is this appointment related to ○ work ○ sports ○ auto

○ personal injury ○ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone _____

Are you receiving care from other health professionals? ○ no ○ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ○ no ○ yes If yes, what month? _____

This form continues. Please turn the page.

Current Health

What are your most pressing health concerns? _____

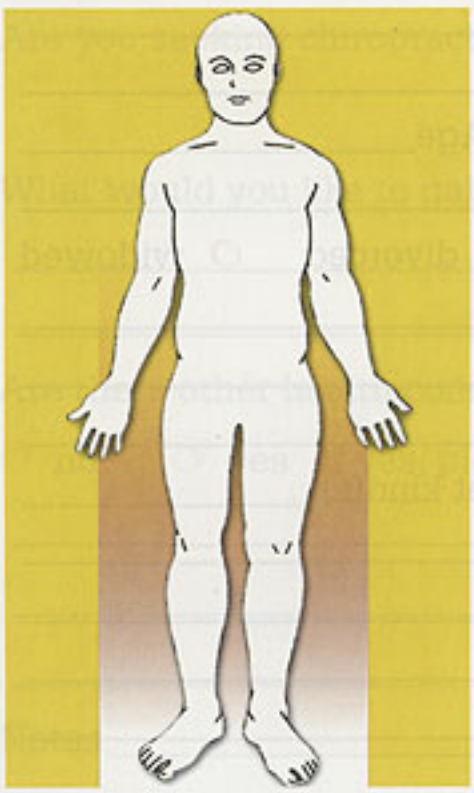
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

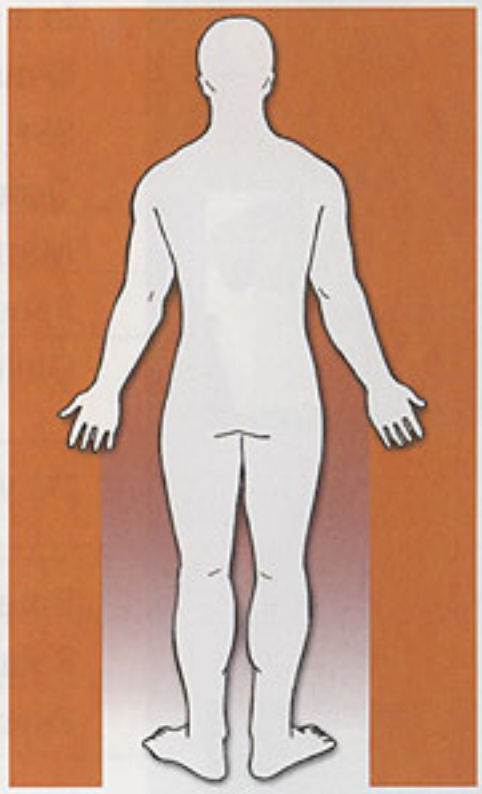
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking ❍ bending ❍ lying down ❍ weather

Please explain _____

Do you feel ❍ cramps ❍ burning ❍ other ❍ swelling ❍ stiffness _____

Do your symptoms interfere with ❍ work ❍ sleep ❍ other ❍ day-to-day activities ❍ play _____

Please explain _____

_____

On a scale of 1-10 *(1 least, 10 most)*, please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Do you have, or have you had, any of the following (*please check ✓ all that apply*)

❍ pneumonia	❍ mumps	❍ influenza	❍ rheumatic fever	❍ smallpox
❍ pleurisy	❍ polio	❍ chickenpox	❍ thyroid disease	❍ diabetes
❍ epilepsy	❍ cancer	❍ depression	❍ whooping cough	❍ anemia
❍ eczema	❍ measles	❍ arthritis	❍ heart disease	❍ rashes

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you use ❍ coffee ❍ tea ❍ artificial sweeteners ❍ sugar ❍ alcohol ❍ cigarettes ❍ recreational drugs

Have you ever suffered from (*please check ✓ all that apply*)

❍ neck pain	❍ stuffy nose	❍ discolored urine
❍ low back pain	❍ allergies	❍ gas/bloating after meals
❍ headache	❍ fainting	❍ heartburn
❍ migraines	❍ weight loss	❍ colitis
❍ arm back/tingling	❍ poor appetite	❍ irritable bowel
❍ shoulder pain	❍ excessive appetite	❍ black or bloody stools
❍ hand pain/tingling	❍ nervousness	❍ constipation
❍ leg pain/tingling	❍ confusion	❍ hemorrhoids
❍ jaw pain	❍ depression	❍ liver problems
❍ chest pain	❍ dental problems	❍ stroke
❍ lung problems	❍ excessive thirst	❍ paralysis
❍ heart problems	❍ frequent nausea	❍ tingling
❍ abnormal blood pressure	❍ vomiting	❍ numbness
❍ irregular heartbeat	❍ prostate problem	❍ fatigue
❍ ankle swelling	❍ breast pain/lump	❍ dizziness
❍ cold extremities	❍ cramps	❍ loss of sleep
❍ blurred vision	❍ painful urination	❍ difficulty hearing
❍ vision problems	❍ bladder trouble	❍ ear pain
❍ difficulty breathing	❍ excessive urination	

If applicable, date of last menstrual period _____

Past injuries can affect present health (*please check ✓ all that apply*)

❍ falls/accidents	❍ head injuries	❍ fights
❍ sports injuries	❍ broken bones	❍ dislocations
❍ spinal tap	❍ surgery	❍ traction
❍ use(d) a cane or walker	❍ extensive dental work	❍ dental appliances
❍ knocked unconscious		

If yes to any of the above, please describe _____

_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what spinal nerve stress/subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

_____

Do any friends or relatives see chiropractors? ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you?

❍ no ❍ yes If yes, please tell us. _____

_____

_____

_____

Notes _____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care?

❍ Cash ❍ Check ❍ Credit Card # _____ Exp. _____

Insurance co. _____ Group Policy # _____

Address _____ Phone # _____

Insured's name _____

Relation _____ Insured's employer _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)

Las Vegas Wellness Coach

Dr. Wendy Scheer

2575 South Cimarron Road; Suite 200
Las Vegas, Nevada 89117
Phone (702) 477 – 0000 Fax (702) 242 – 0016
Website: www.lasvegaswellnesscoach.com

"To Coach, educate, and adjust as many families and people as possible towards optimum wellness through natural Chiropractic and Wellness Care"

Office Policy

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt services and provide the best family health care available. In return, you will receive restored health and wellness. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

Office Hours:

Our office is open Monday thru Friday with emergency hours on Saturday and Sunday. Our hours vary so please call (702) 477–0000 to make an appointment. When you call please let the scheduler know if you are calling for an appointment that involves:

*Nutrition Counseling/Programs *Hormone Balancing *Body Fat Analysis
*BioMeridian Testing (Acuppuncture Point Testing) *Weight Management *Allergy Testing

For your convenience and to ensure prompt reliable service, we prefer that you pre-schedule your appointments. Please provide 24 hours notice when rescheduling an appointment so that Dr. Scheer may serve others during your appointment time.

Initials_____

Email:

Dr. Scheer sends a monthly news letter via Email to her patients regarding Chiropractic/Nutrition care and updates. If you would like to receive a copy of this please print your Email address on the line provided _____

Initials_____

Children & Family:

Once you understand how the nervous system controls and coordinates all functions in the body and that subluxation interferes with nerve flow, we would expect that you would want everyone in your family checked for subluxations. We have a cost effective family program for you. *We will be happy to schedule an appointment for their checkup today!*

Initials_____

Half Hour to Health Workshop:

Dr. Scheer provides the opportunity to enhance your understanding of Wellness and Chiropractic care, answer your questions and teach you how to stay healthy naturally. All new patients are encouraged to attend this workshop. You are welcome to bring a family member or friend. *This workshop is a benefit of care in our office, therefore there is no charge to attend.*

Initials_____

Remember…

Healing and spinal correction takes time. If at any time during your care you do not feel that you are responding as well as you expected, please, discuss it with Dr. Scheer. We want you to get the most from your Chiropractic Care!

Initials_____

Referrals:

The greatest honor a patient can give to their doctor is a referral of their family and friends. We promise to give your loved ones the same quality, love, and attention that you receive. We also want to thank you in advance…….THANK YOU!

Initials_____

Qmmunicate:

Qmmunicate is an automated system that will call the day prior to your appointment to remind you of the time. This system will leave a message on a recorder or with the person answering the phone. If you agree to using this system mark the appropriate box.

_____ Yes _____ No thank you I do not want my appointment confirmed

Initials_____

Receipt of Privacy Practices:

I,_____ (patient's initials), acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Las Vegas Wellness Coach; Dr. Wendy Scheer, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by Las Vegas Wellness Coach; Dr. Wendy Scheer.

Initials_____

Medical and General Authorization form:

This is to be used to authorize my physicians(s), hospital, medical attendants, attorneys, or others to furnish Las Vegas Wellness Coach; Dr. Wendy Scheer with any and all information or opinions which she may request regarding my physical condition and any treatment rendered therefore, and to allow her to see and or copy any x-rays, reports or records which you may have regarding my condition or treatment.

Dr. Wendy Scheer would like to keep your Medical Doctor informed of your progress. If you agree to our office sending your Medical Doctor records from our office please mark the appropriate spot and put their information on the lines provided.

Yes, send information to Dr._____ Phone_____

No, please do not send records to my Medical Physician _____

It is understood and agreed that a photocopy of this authorization shall have the same force and effect as the original.

Patient's Signature:_____ **Date:**_____

Printed Name:_____