

# WELCOME TO ACN ALLEN CHIROPRACTIC NEUROLOGY

## Five Standards for New Patients

1.	All new patients are required to fill out a personal health questionnaire. Some items on the first page will have to be written down a second time.
2.	You will have a personal consultation with the doctor to discuss your intake form and health problems.
3.	The doctor will perform diagnostic chiropractic, orthopedic, and neurological examination procedures.
4.	You will be advised if there is a need for additional procedures such as X-rays, MRI, or CT Scan.
5.	You will have a personal discussion with the doctor to discuss your care plan and treatment.

## Confidential Patient Information

Name		Date
Address		City/State/Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone/Pager ( )
Email Address	Date of Birth	Current Age

**Work Status:**    Employed    Retired    Disabled    Full-time Student    Part-time Student

Employer	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

**Marital Status:**    Married    Single    Divorced    Widow    Spouse's Name \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

### FEMALES ONLY – IN REFERENCE TO RADIOGRAPHIC IMAGING

I, _____, to the best of my knowledge confirm that I am not pregnant, and waive all responsibility to the Doctor.	
Signature:	Date:

### MINORS ONLY – CONSENT FOR TREATMENT

I hereby authorize Dr. Julia Allen and whomever she may so designate as her assistant, to administer chiropractic care as she deems necessary to my son/daughter, _____, dated at Georgetown, TX this _____ day of _____, 20____.	
Signature:	Witnessed:

### ALL PATIENTS – IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone ( )	Work Phone ( )	Cell Phone ( )

ACN NEW PATIENT CHECKLIST PAGE 2

**Please list your major ailments in order of severity (from most debilitating to least debilitating):**

1.	4.
2.	5.
3.	6.

**Primary Ailment** - \_\_\_\_\_

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant (100% of day) <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __ Sitting for __ min., __ Standing, __ Walking, __ Lying, __ Pushing, __ Pulling, __ Lifting __ lbs., __ Gripping Hot/Cold, __ Coughing/sneezing, __ Bowel Movements, __ Mental Activities, __ Bright lights, __ Other _____, __ Other _____, __ Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.)


Please include any other relevant history in regards to this ailment.


ACN NEW PATIENT CHECKLIST PAGE 3

**Additional Ailment** - \_\_\_\_\_

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms Spread? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant (100% of day) <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating pain): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10
Is your pain <input type="checkbox"/> Deep or <input type="checkbox"/> Superficial
Please indicate the character of your pain: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Knife-like Throbbing
Are you experiencing any of the following associated symptoms? <input type="checkbox"/> Pins/Needles <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Twitching If Yes, Please describe:
Please indicate what activities provoke (P) or Aggravate (A) your condition: __ Sitting for __ min., __ Standing, __ Walking, __ Lying, __ Pushing, __ Pulling, __ Lifting __ lbs., __ Gripping Hot/Cold, __ Coughing/sneezing, __ Bowel Movements, __ Mental Activities, __ Bright lights, __ Other _____, __ Other _____, __ Other _____
Please indicate what helps to alleviate the pain. <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Rest <input type="checkbox"/> Heat/Cold <input type="checkbox"/> Medications _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Please list what doctors you have seen for this condition. (Please include diagnoses, treatment received, and any changes in your condition.


Please include any other relevant history in regards to this ailment.


**IF YOU HAVE MORE THAN TWO AILMENTS, PLEASE ASK THE RECEPTIONIST FOR ADDITIONAL "AILMENT" FORMS.**

**Past Medical History**

Please include any of your previous conditions.

If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

**General Health History: Have YOU had any of the following?**

Injuries, Accidents, Falls or Traumas:  No  Yes Explain:

Illnesses/Hospitalizations:  No  Yes Explain:

Surgeries:  No  Yes Explain:

Motor Vehicle Accidents:  No  Yes Explain:

Work Injuries:  No  Yes Explain:

Females Only - Menopausal Symptoms:  None  Yes Explain:

**Habits**

Cigarettes/Cigars	<input type="checkbox"/> None <input type="checkbox"/> Yes	How much per week?
Alcohol	<input type="checkbox"/> None <input type="checkbox"/> Yes	How many drinks per week? What type of Alcohol?
Coffee	<input type="checkbox"/> None <input type="checkbox"/> Yes	How many cups per week?
Exercise	<input type="checkbox"/> None <input type="checkbox"/> Yes	Hours/Days per week? Types?
Water	<input type="checkbox"/> None <input type="checkbox"/> Yes	Glasses per day?
Soft Drinks	<input type="checkbox"/> None <input type="checkbox"/> Yes	Amount per week? Types?
Sleep	<input type="checkbox"/> None <input type="checkbox"/> Yes	Average per night? Do you have difficulty falling asleep or staying asleep? Hours desired per night?
Eating	<input type="checkbox"/> None <input type="checkbox"/> Yes	Meals per day? What types of food do you eat? Do you consider your diet healthy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:

**Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?**

Diabetes  Heart Disease  Stroke  Neurological Disorders \_\_\_\_\_  
 Autoimmune Disorders \_\_\_\_\_  Cancer \_\_\_\_\_  
 Other \_\_\_\_\_

**Personal Health History**

<b>Medications:</b> Please list your current medications, how long you have been taking them and for what they are taken.
<b>Vitamins and Minerals:</b> Please list your current supplements.

Check the left box for any condition YOU had in the PAST, and the right box for any condition YOU have CURRENTLY.

**GENERAL HEALTH HISTORY**

P	C	P	C	P	C	P	C				
<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Infective Disease
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Fungal Infection
<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox

<u>NERVOUS SYSTEM</u>		<u>EYES/EARS/NOSE/THROAT</u>		<u>GASTROINTESTINAL</u>		<u>MUSCULOSKELETAL</u>								
P	C	P	C	P	C	P	C							
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor/Excess Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashing Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Chewing
<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Black Spots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Face Pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurriness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Black/Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>	Arm/Elbow Pain
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Wrist/Hand Pain
<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Cramping	<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Poor Balance					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gas/Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Twitches/Tremor					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Thigh/Knee Pain
<input type="checkbox"/>	<input type="checkbox"/>	Cold/Tingle Extremities					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Difficulties					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Walking
<input type="checkbox"/>	<input type="checkbox"/>	Headaches					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Leg/Arm Fatigue

<u>CARDIOVASCULAR</u>		<u>REPRODUCTIVE</u>		<u>GENITOURINARY</u>							
P	C	P	C	P	C						
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discolored Urine
<input type="checkbox"/>	<input type="checkbox"/>	Lung/Congestion Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Infection					
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins									
<input type="checkbox"/>	<input type="checkbox"/>	Ankle Swelling									

How many times per day do you urinate?	How often do you have a bowel movement?
Do you experience any <input type="checkbox"/> urgency, <input type="checkbox"/> dribbling, or <input type="checkbox"/> incontinence?	Do your stools <input type="checkbox"/> Float or <input type="checkbox"/> Sink?
Is this urination pattern consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your bowel movements consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No

**CONFIDENTIALITY**

**In the event this office needs to contact you:**

May we leave a message for you with someone at your home phone number?  Yes  No

May we leave a message for you on your home answering machine?  Yes  No

May we leave a message for you with someone at your work phone number?  Yes  No

May we leave a voice mail message for you on your cell phone?  Yes  No

May we fax information that you request?  Yes  No

**Assignment of Benefits-Financial Agreement:**

I hereby give authorization for payment to be made directly to Allen Chiropractic Neurology, for all services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I understand and agree to the above information.

Name of Patient(s): \_\_\_\_\_

Signature of person authorized to sign for patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_