NEW PATIENT FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No Email address: Cell Phone No.: ( ) Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home Phone No.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr.

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ SORSI Website ❑Other

Other family members seen here:

DECLARATION OF PAYMENT

(Please give your insurance card to the receptionist.)

The polices of this office are that fees are payable as services are rendered. These services include examinations, treatments, x-rays, and therapies. Unless other arrangements have been made in advance, your account must be taken care of at the end of each visit.

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 signed over to me upon 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Heath Care and I give authority for these procedures to be preformed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patient may obtain copies of their file upon request. Copying fees may apply.

PLEASE INICATE HOW YOU WISH TO HANDLE YOUR ACCOUNT

❑ CASH ❑ CHECK ❑ MC/VISA/AMEX ❑ SPECIAL ARRANGEMENTS

Name of Insurance: Subscriber's name: Subscriber's S.S. no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate

Patient/Guardian signature *Date*

Welcome

It is our pleasure to welcome you to the Midwest Chirodontic Institute. We are here to help you achieve your health goals. We offer many different types of services; all aimed at helping your body heal faster and more efficiently.

When you begin your health journey, it is important to take note of all your symptoms.

These are warning signs that your body is in trouble. Although it is possible to eliminate many symptoms quickly; finding and eliminating the root or cause of the symptoms is ultimately our goal.

However, the choice is yours.

We offer 3 types of Care: PLEASE CHOOSE ONE

____**Intensive Care**: corrects the most recent spinal damage and **reduces** or eliminates **symptoms**—takes about 6-10 weeks of care.

____**Reconstructive Care**: **corrects** the years of **physical and spinal damage** that occurred when there were few symptoms—can take 3 months to years.

____**Wellness Care**: is aimed at helping you **maintain** all the corrections you have received and allows you to **increase your personal health** and well being—a wonderful life long journey.

We believe that **Health** should be a major priority in one's life. We find it is much easier to **Stay Healthy** than to get healthy. Therefore, adhering to your treatment plan will ensure that you will maintain the progress that is being made within your structural and physiological system. This will allow you to advance to a healthier, happier state of being much quicker.

We recommend that you schedule your appointments well in advance. This will reserve your favorite time spot. If you are running late for an appointment, please call and let us know as a courtesy to the other patients. Your undisturbed treatment time is very important to us, and we like to be on time for appointments.

If you are unable to make your schedule appointment, we would appreciate 24 hours notice. If an emergency arises, we understand. However, appointments that are not cancelled within 24 hours may be subject to a Missed Appointment Fee of $35 and $50 on Saturdays.

We believe in giving each patient all the services they need and choose not to be monetarily dictated by insurance company's reimbursement fees. Therefore, we have chosen to have a **Cash practice**. This means, payment is due as services are rendered, unless other arrangements have been made. This choice is a result of having to sacrifice **Quality for Quantity** for many years.

We accept **C**ash, **C**hecks, **M**astercard, **V**isa, and **Discover**

Our **office hours** are:

Tuesday's through Saturday: By appointment only

The office **Phone** number is : 314-541-6230

In case of **emergency** you may call : cell # 314-541-6230

THE BEST COMPLIMENT YOU CAN GIVE US IS THE REFERRAL OF YOUR FAMILY AND FRIENDS. WE THANK YOU FOR THE CONFIDENCE YOU HAVE PLACED IN US AND LOOK FORWARD TO SERVING YOU AND YOUR LOVED ONES.

I have read the above information and understand it to the best of my ability. I agree to all the terms and conditions.

SIGNATURE:_____ **DATE:**_____

PATIENT CONDITION AND HISTORY

Reason for Visit_____

Is this condition getting progressively worse? ____yes ____no ____unknown

Is this condition interfering with Work?_____ Sleep?_____ Routine?_____

What other Doctors or treatment have you received for this condition?

Medications_____ Surgery_____ Physical Therapy_____ Chiropractic_____

None_____ Other_____

Doctor's names:_____

Any Home Remedies?_____

Date of last: Physical Exam_____ Spinal X-ray_____ Blood Test_____

Spinal Exam _____ Chest X-ray_____ Urine Test_____

Dental X-ray _____ MRI CT, Bone Scan_____

Are you pregnant?_____yes _____no Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Motor Vehicle Accidents:		
Surgeries:		

Doctor comments _____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS**

PATIENT SYMPTOMS

Check if you presently have or had in the past any of these symptoms.

GENERAL SYMPTOMS

___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness or pain in arms/legs/hands
___ Allergy (What kind?)
_____
_____
___ Wheezing
___ Neuralgia

GASTRO-INTESTINAL

___ Poor Appetite
___ Poor Digestion
___ Starvation
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain Over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids
___ Fluid Retention
___ Liver Trouble
___ Gout
___ Jaundice
___ Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

___ Poor Vision
___ Crossed Eyes
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharges
___ Nasal Obstructions
___ Nose Bleeds
___ Sore Throats
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Enlarged Thyroid
___ Tonsillitis
___ Sinus Trouble

RESPIRATORY

___ Chromic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing

GENITO-URINARY

___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Inability to control Urine
___ Prostate Trouble

DOCTOR'S NOTES:

PATIENT SYMPTOMS

PAGE 2

MUSCLES & JOINTS

___ Weakness

___ Twitching

___ Stiff Neck

___ Backache

___ Swollen Joints

___ Tremors

___ Foot Trouble

___ Painful Tail Bone

___ Pain Between Shoulders

___ Spinal Curvature

CARDIO-VASCULAR

___ Rapid Heart

___ Slow Heart

___ High Blood Pressure

___ Low Blood Pressure

___ Pain Over Heart

___ Heart Trouble

___ Swelling Ankles

___ Poor Circulation

___ Varicose Veins

___ Strokes

___ Palpitations

SKIN OR ALLERGIES

___ Skin Eruptions

___ Itching

___ Bruising Easily

___ Dryness

___ Boils

___ Sensitive Skin

___ Hives or Allergy

___ Eczema

___

FOR WOMEN ONLY

___ Painful Periods

___ Excessive Flow

___ Irregular Cycle

___ Hot Flashes

___ Cramps or Backaches

___ Vaginal Discharge

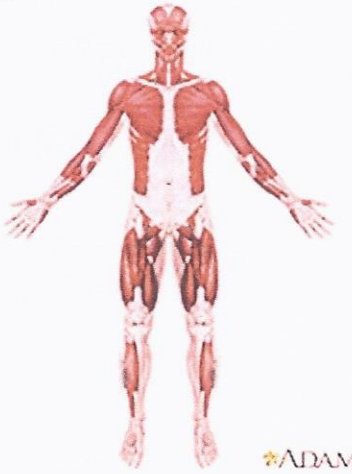
DOCTOR NOTES:

MARK PAIN REGION

Burning * Stabbing * Sharp* Constant

Example: Neck _____sharp_____
1 2 3 4 5 6 7 080 9 10

Right Left



Mark Pain Area			
+++	Burning	---	Sharp
000	Stabbing	///	Constant
XXX	Other		

Left Right

Severity of Pain and Region of Pain (1= Least, 10=greatest)

1) Neck _____
1 2 3 4 5 6 7 8 9 10

2) Mid Back _____
1 2 3 4 5 6 7 8 9 10

3) Low Back _____
1 2 3 4 5 6 7 8 9 10

4) Hips_____
1 2 3 4 5 6 7 8 9 10

5) Arms/Hands _____
1 2 3 4 5 6 7 8 9 10

6) Legs/Feet _____
1 2 3 4 5 6 7 8 9 10

DOCTOR NOTES

When did your symptoms first appear? _____

What activities aggravate your condition/pain? _____

What activities lessen your pain? _____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily

HABITS

- ☐ Smoking Packs/Day _____
- ☐ Alcohol Cups/Day _____
- ☐ Coffee Cups/Day _____
- ☐ Soda Pop Cups/Day

HEADACHES SYMPTOMS

1) When did your headaches start? Please give approximate date.

_____

2) What do you think causes your headaches?

_____

3) How have they progressed?
Please circle the # that represents their severity. 10=worst, 1= no pain.

A. When they first began:

10 9 8 7 6 5 4 3 2 1

B. Presently:

10 9 8 7 6 5 4 3 2 1

4) Where do they hurt, specifically?

_____

5) Are they. . . : (Circle all that apply) Always there? Come and go? Sharp? Dull?

6) Is there pressure. . .: (Circle one) Behind the eyes? Below the eyes? Above the eyes?

7) Do they go. . .: (Circle one) Around the head? Through the head? Over the head?

8) Do they radiate? (Circle one) Yes. No.

9) Do they hurt from: (Circle one and explain) Inside-out. Outside-in.

_____

10) Do they pound? (Circle one) No. Yes. If so, where? _____

11) When do they usually start? (Circle one) AM. PM. No Pattern.

12) Has your vision or sense of smell changed? (Circle one) Yes. No.

13) What makes them better? _____

14) What makes them worse? _____

15) Where do they start and end from? _____

16) What have already tried that has failed to ease these symptoms? _____

_____

CONSENT AND AUTHORIZATION FOR THE PURPOSE OF CHIROPRACTIC EXAMINATION AND TREATMENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body, and since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures.

POSSIBLE ADVERSE EFFECTS OF CHIROPRACTIC ADJUSTMENTS

Lumbar Adjustments

The risks of Chiropractics treatment are generally extremely low. Cauda equine syndrome is usually described as the most serious accident that can result from lumbar adjusting. This results from the compression of the cauda equine in the lower spinal canal. Cauda equine refers to the bundle of nerves that hangs from the spinal cord below the protection of the vertebra. The immediate effect can be dramatic loss of bowel and bladder function. Colleagues estimate the occurrence of cauda equine syndrome from lumbar adjusting to be less than one in ten million.

Other risks that may occur, but are not limited to are: fracture, dislocation, disc rupture, strain-sprain, or worsening of symptoms.

Cervical Adjustments

Reports of stroke or other serous complications from cervical adjustments have appeared in the medical literature since 1934. Estimates have shown that the incidence of stroke from Chiropractic adjustments of the neck is between one and three injuries per million adjustments.

Other risks that may occur, but are not limited to are: fracture, dislocation, disc rupture, sprain-strain, paralysis, or worsening of symptoms.

Thoracic Adjustments

Other risks that may occur, but are not limited to are: fracture (rib) , dislocation, disc rupture, sprain-strain, or worsening of symptoms.

Extremities

Risks that may occur are: fracture, dislocation, joint swelling, hemarthrosis, muscular, ligamentous, tendon injuries, sprain-strain, or worsening of symptoms.

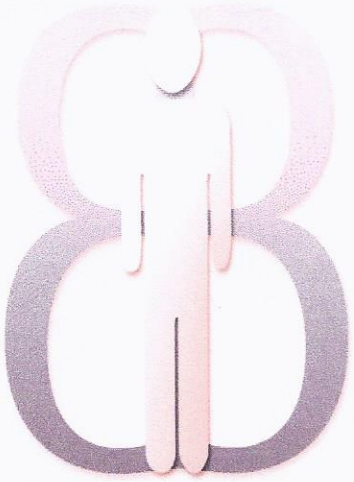
All risks, benefits and alternatives have been explained to me by my physician before treatment, and I understand that I have had the opportunity to inquire about any of my concerns or questions regarding my examination and treatment before, during and after.

I also understand that if my medical condition changes, I will notify Dr. Walker immediately of these changes prior to continuing treatment.

Signature:_____

Print Name_____

Date_____



Midwest Chirodontic Institute

456N. New Ballas Rd. Ste. 103

St. Louis, MO 63141

314-541-6230

NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received the NOTICE OF PRIVACY PRACTICES. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

Signature: _____

Date: _____

CONSENT FORM
For
Photograph release

I, the undersigned_____
Do hereby give Dr. Michelle Walker permission to use the photographs taken in her office for the use of educational and promotional material.
These photographs will not be used on the internet or for public display.
Their sole purpose is for the demonstration of the cranial and structural work that Dr. Walker performs.
I do hereby wave my rights of these photographs so that they may be used for educational and demonstrational l purposes.

Signed:_____

Date:_____

Witness:_____