Welcome to Phillips Family Chiropractic

1 PATIENT INFORMATION

Date ______________________

Patient Name ______________________
Last Name

____
First Name Middle Initial

SS# ______________________

Mailing Address ______________________

Street Address ______________________

City ______________________

State ____________ Zip ____________

E-mail ______________________

Sex ☐ M ☐ F Age ____________

Birthdate ______________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Patient Employer/School ______________________

Occupation ______________________

Employer/School Address ______________________

____

Employer/School Phone (____) ______________________

Whom may we thank for referring you? ______________________

Name of Primary Care Physician ______________________

Phone # ______________________

May we contact this physician if we need to: ☐ Yes ☐ No

2 FINANCIAL POLICY

We are a CASH PRACTICE.
This means payment (cash, check, or credit cards) is due at the time of service. We opt out of the "insurance game" to keep our costs at a minimum, and to keep the bureaucracy from interfering with your health. We think you're worth it.

INSURANCE
We can provide you with a comprehensive receipt which will indicate the type of services performed and the corresponding treatment codes. You may submit this receipt to your insurance company for reimbursement.

MEDICARE
We are required by law to submit claims to medicare. We submit these claims on a weekly basis. We submit these claims as unassigned, meaning that the reimbursement check should come to you.

NO SHOW FEE
There is a $20.00 charge for missed appointments when there is no prior notification given. Communication with our office is important.

BE RESPONSIBLE FOR YOUR HEALTH
It is imperative that you keep your appointments. The timing of these is specifically designed to support your recovery and maintain your overall health. Repeatedly rescheduling cannot only compromise the benefits of treatment, but may even extend that treatment beyond the care plan limits, costing you more in the long run.

I understand that I am financially responsible for all services rendered. I authorize the release of my health care information in the event I need assistance in obtaining payment from my insurance company. To the best of my knowledge, I have provided complete and truthful information.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (______) __________ Home Phone (______) __________

Best time and place to reach you ______________________

IN CASE OF EMERGENCY, CONTACT

Name ______________ Relationship ______________

Home Phone (______) __________ Work Phone (______) __________

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date ____________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (If applicable) ______________________

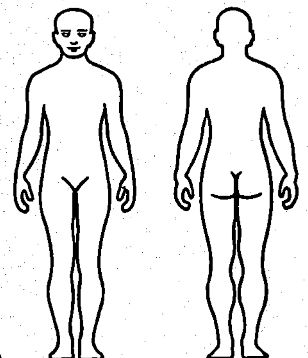
5 PATIENT CONDITION

Reason for Visit ______________________

When did your symptoms appear? ______________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) __________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ______________________

Is it constant or does it come and go? ______________________

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

– O V E R –

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition ____________________

Date of Last: Physical Exam __________ Spinal X-Ray __________ Blood Test __________

Spinal Exam __________ Chest X-Ray __________ Urine Test __________

Dental X-Ray __________ MRI, CT-Scan, Bone Scan __________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition		Condition		Condition		Condition	
AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other __________	
		Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	__________	

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking — Packs/Day __________
☐ Alcohol — Drinks/Week __________
☐ Coffee/Caffeine Drinks — Cups/Day __________
☐ High Stress Level — Reason __________

Are you pregnant? ☐ Yes ☐ No Due Date ____________________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
__________	__________	__________
__________	__________	__________
__________	__________	__________
Pharmacy Name __________	__________	__________
Pharmacy Phone (____) __________	__________	__________

SYSTEMS SURVEY FORM

(Restricted to Professional Use)

PATIENT____________________ AGE______ HEALTH CARE PROFESSIONAL________________ DATE__________

INSTRUCTIONS: Circle the number that applies to you. If a symptom does not apply, leave it blank. Circle either: (1) for MILD symptoms (occurs rarely), (2) for MODERATE symptoms (occurs several times a month), or (3) for SEVERE symptoms (occurs almost constantly).

GROUP ONE

1 – 1 2 3 Acid foods upset
2 – 1 2 3 Get chilled, often
3 – 1 2 3 "Lump" in throat
4 – 1 2 3 Dry mouth-eyes-nose
5 – 1 2 3 Pulse speeds after meal
6 – 1 2 3 Keyed up - fail to calm
7 – 1 2 3 Gag occasionally
8 – 1 2 3 Unable to relax, startles easily
9 – 1 2 3 Extremities cold, clammy
10 – 1 2 3 Strong light irritates
11 – 1 2 3 Occasionally weak urine flow
12 – 1 2 3 Heart pounds after retiring
13 – 1 2 3 "Nervous" stomach
14 – 1 2 3 Appetite reduced occasionally
15 – 1 2 3 Cold sweats often
16 – 1 2 3 Get heated easily
17 – 1 2 3 Nerve discomfort
18 – 1 2 3 Staring, blinks little
19 – 1 2 3 Sour stomach frequent

GROUP TWO

20 – 1 2 3 Joint stiffness after arising
21 – 1 2 3 Muscle-leg-toe cramps at night
22 – 1 2 3 "Butterfly" stomach, cramps
23 – 1 2 3 Eyes or nose watery
24 – 1 2 3 Eyes blink often
25 – 1 2 3 Eyelids swollen, puffy
26 – 1 2 3 Indigestion soon after meals
27 – 1 2 3 Always seem hungry; feels "lightheaded" often
28 – 1 2 3 Digestion rapid
29 – 1 2 3 Vomiting occasionally
30 – 1 2 3 Hoarseness frequent
31 – 1 2 3 Uneven breathing
32 – 1 2 3 Pulse slow
33 – 1 2 3 Gagging reflex slow
34 – 1 2 3 Difficulty swallowing
35 – 1 2 3 Temporary constipation or diarrhea
36 – 1 2 3 "Slow starter"
37 – 1 2 3 Get "chilled"
38 – 1 2 3 Perspire easily
39 – 1 2 3 Sensitive to cold
40 – 1 2 3 Upper respiratory challenges

GROUP THREE

41 – 1 2 3 Eat when nervous
42 – 1 2 3 Excessive appetite
43 – 1 2 3 Hungry between meals
44 – 1 2 3 Irritable before meals
45 – 1 2 3 Get "shaky" if hungry
46 – 1 2 3 Fatigue, eating relieves
47 – 1 2 3 "Lightheaded" if meals delayed
48 – 1 2 3 Heart palpitates if meals missed or delayed
49 – 1 2 3 Fatigue in afternoons
50 – 1 2 3 Overeating sweets upsets
51 – 1 2 3 Awaken after few hours' sleep - hard to get back to sleep
52 – 1 2 3 Crave candy or coffee in afternoons
53 – 1 2 3 Moods of "blues" or melancholy
54 – 1 2 3 Craving for sweets or snacks

GROUP FOUR

55 – 1 2 3 Hands and feet go to sleep easily, numbness
56 – 1 2 3 Sigh frequently, "air hunger"
57 – 1 2 3 Aware of "breathing heavily"
58 – 1 2 3 High altitude discomfort
59 – 1 2 3 Opens windows in closed room
60 – 1 2 3 Immune system challenges
61 – 1 2 3 Afternoon "yawner"
62 – 1 2 3 Get "drowsy" often
63 – 1 2 3 Swollen ankles worse at night
64 – 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
65 – 1 2 3 Difficulty catching breath, especially during exercise
66 – 1 2 3 Tightness or pressure in chest, worse on exertion
67 – 1 2 3 Skin discolors easily after impact
68 – 1 2 3 Tendency to anemia
69 – 1 2 3 Noises in head, or "ringing in ears"
70 – 1 2 3 Fatigue upon exertion

GROUP FIVE

71 – 1 2 3 Dizziness
72 – 1 2 3 Dry skin
73 – 1 2 3 Burning feet
74 – 1 2 3 Blurred vision
75 – 1 2 3 Itching skin and feet
76 – 1 2 3 Hair loss
77 – 1 2 3 Occasional skin rashes
78 – 1 2 3 Bitter, metallic taste in mouth in mornings
79 – 1 2 3 Occasional constipation
80 – 1 2 3 Worrier, feels insecure
81 – 1 2 3 Nausea occasionally after eating
82 – 1 2 3 Greasy foods upset
83 – 1 2 3 Stools light-colored
84 – 1 2 3 Skin peels on foot soles
85 – 1 2 3 Discomfort between shoulder blades
86 – 1 2 3 Occasional laxative use
87 – 1 2 3 Stools alternate from soft to watery
88 – 1 2 3 Sneezing attacks
89 – 1 2 3 Dreaming, nightmare type bad dreams
90 – 1 2 3 Bad breath (halitosis)
91 – 1 2 3 Milk products cause upset
92 – 1 2 3 Sensitive to hot weather
93 – 1 2 3 Burning or itching anus
94 – 1 2 3 Crave sweets

GROUP SIX

95 – 1 2 3 Loss of taste for meat
96 – 1 2 3 Lower bowel gas several hours after eating
97 – 1 2 3 Burning stomach sensations, eating relieves
98 – 1 2 3 Coated tongue
99 – 1 2 3 Pass large amounts of foul-smelling gas
100 – 1 2 3 Indigestion ½ - 1 hour after eating; may be up to 3-4 hours after
101 – 1 2 3 Watery or loose stool
102 – 1 2 3 Gas shortly after eating
103 – 1 2 3 Stomach "bloating"

GROUP SEVEN

GROUP 7A

104 – 1 2 3 Difficulty sleeping
105 – 1 2 3 On edge
106 – 1 2 3 Can't gain weight
107 – 1 2 3 Intolerance to heat
108 – 1 2 3 Highly emotional
109 – 1 2 3 Flush easily
110 – 1 2 3 Night sweats
111 – 1 2 3 Thin, moist skin
112 – 1 2 3 Inward trembling
113 – 1 2 3 Heart races
114 – 1 2 3 Increased appetite without weight gain
115 – 1 2 3 Pulse fast at rest
116 – 1 2 3 Eyelids and face twitch
117 – 1 2 3 Irritable and restless
118 – 1 2 3 Can't work under pressure

GROUP 7B

119 – 1 2 3 Increase in weight
120 – 1 2 3 Decrease in appetite
121 – 1 2 3 Fatigue easily
122 – 1 2 3 Ringing in ears
123 – 1 2 3 Sleepy during day
124 – 1 2 3 Sensitive to cold
125 – 1 2 3 Dry or scaly skin
126 – 1 2 3 Temporary constipation
127 – 1 2 3 Mental sluggishness
128 – 1 2 3 Hair coarse, falls out
129 – 1 2 3 Tension in head upon arising wears off during day
130 – 1 2 3 Slow pulse, below 65
131 – 1 2 3 Changing urinary function
132 – 1 2 3 Sounds appear diminished
133 – 1 2 3 Reduced initiative

GROUP 7C

134 – 1 2 3 Failing memory with age
135 – 1 2 3 Increased sex drive
136 – 1 2 3 Episodes of tension in head
137 – 1 2 3 Decreased sugar tolerance

GROUP 7D

138 – 1 2 3 Abnormal thirst
139 – 1 2 3 Bloating of abdomen
140 – 1 2 3 Weight gain around hips or waist
141 – 1 2 3 Sex drive reduced or lacking
142 – 1 2 3 Tendency for stomach issues
143 – 1 2 3 Increased sugar tolerance
144 – 1 2 3 Menstrual disorders

GROUP 7E

145 – 1 2 3 Dizziness
146 – 1 2 3 Headaches
147 – 1 2 3 Hot flashes
148 – 1 2 3 Hair growth on face or body (female)
149 – 1 2 3 Sugar in urine (not diabetes)
150 – 1 2 3 Masculine tendencies (female)

GROUP 7F

151 – 1 2 3 Weakness, dizziness
152 – 1 2 3 Tired throughout day
153 – 1 2 3 Nails, weak, ridged
154 – 1 2 3 Sensitive skin
155 – 1 2 3 Stiff joints
156 – 1 2 3 Perspiration increase
157 – 1 2 3 Bowel discomfort
158 – 1 2 3 Poor circulation
159 – 1 2 3 Swollen ankles
160 – 1 2 3 Crave salt
161 – 1 2 3 Areas of skin darkening
162 – 1 2 3 Upper respiratory sensitivity
163 – 1 2 3 Tiredness
164 – 1 2 3 Breathing challenges

GROUP EIGHT

165 – 1 2 3 Muscle weakness
166 – 1 2 3 Lack of stamina
167 – 1 2 3 Drowsiness after eating
168 – 1 2 3 Muscular soreness
169 – 1 2 3 Heart races
170 – 1 2 3 Hyper-irritable
171 – 1 2 3 Feeling of a band around your head
172 – 1 2 3 Melancholia (feeling of sadness)
173 – 1 2 3 Swelling of ankles
174 – 1 2 3 Change in urinary function
175 – 1 2 3 Tendency to consume sweets/carbohydrates
176 – 1 2 3 Muscle spasms
177 – 1 2 3 Blurred vision
178 – 1 2 3 Involuntary muscle action
179 – 1 2 3 Numbness
180 – 1 2 3 Night sweats
181 – 1 2 3 Rapid digestion
182 – 1 2 3 Sensitivity to noise
183 – 1 2 3 Redness of palms of hands and bottom of feet
184 – 1 2 3 Visible veins on chest and abdomen
185 – 1 2 3 Hemorrhoids
186 – 1 2 3 Apprehension (feeling that something bad is going to happen)
187 – 1 2 3 Nervousness causing loss of appetite
188 – 1 2 3 Nervousness with indigestion
189 – 1 2 3 Gastritis
190 – 1 2 3 Forgetfulness
191 – 1 2 3 Thinning hair

FEMALE ONLY

192 – 1 2 3 Very easily fatigued
193 – 1 2 3 Premenstrual tension
194 – 1 2 3 Menses more painful than usual
195 – 1 2 3 Depressed feelings before menstruation
196 – 1 2 3 Painful breasts during menses
197 – 1 2 3 Menstruate too frequently
198 – 1 2 3 Hysterectomy/ovaries removed
199 – 1 2 3 Menopausal hot flashes
200 – 1 2 3 Menses scanty or missed
201 – 1 2 3 Acne, worse at menses

MALE ONLY

202 – 1 2 3 Less involved in exercise/social activities
203 – 1 2 3 Difficult to postpone urination
204 – 1 2 3 Weak urinary stream
205 – 1 2 3 Feeling of "blues" or melancholy
206 – 1 2 3 Feeling of incomplete bowel evacuation
207 – 1 2 3 Lack of energy
208 – 1 2 3 Muscles in arms and legs seem softer/smaller
209 – 1 2 3 Tire too easily
210 – 1 2 3 Avoids activity
211 – 1 2 3 Leg nervousness at night
212 – 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Postural Blood Pressure: Recumbent ____________ Standing ____________ Pulse ____________

Hema-Combistix Urine readings: pH ____________ Albumin per cent ____________ Glucose per cent ____________

Occult Blood ____________ pH of Saliva ____________ pH of Stool specimen ____________ Weight ____________

Hemoglobin ____________ Blood Clotting Time ____________

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (Any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (The 2nd and 3rd day of flow or any 5 days in a row)
MALES (Any 2 days during the month)

RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.