Welcome

I would like to take this opportunity to welcome you to my office. My goal is to help you gain better health in the least amount of time and expense to you. To help my office run as efficiently as possible, I would like to review my office policies to avoid possible future misunderstandings.

All patients are expected to pay in full at the time of service, as I am not contracted by any insurance company. It will be the patient's responsibility to contact their provider to determine if they have **OUT OF NETWORK** chiropractic coverage. As a courtesy to those who have **OUT OF NETWORK** chiropractic coverage, your submissions will be sent electronically. If there are any issues, you will be the primary contact with the insurance company.

Payments may be made via cash, check, or major credit cards.

I make it a daily goal to stay on schedule, however, emergencies do occur. I appreciate your promptness with scheduled appointments. **We ask that a 24 hour notice be given if you cannot keep your scheduled appointment so that we may serve others in need. A fee will be charged to all cancels, transfers, and no shows without a 24 hour notice.**

I appreciate the opportunity you are giving us to participate in your journey to better health and wellness. "Your Health is our main concern!!!"

Anytime you need assistance, please feel free to talk to Cindy.

Yours in Health,

Dr. Christopher Thoma and Staff

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE

Signature:_____DATE:_____

TOTAL HEALTH CORRECTION
WELLNESS AND CHIROPRACTIC

300 Ozark Trail Dr. Ste 105
Ellisville, MO 63011
(636) 207-6600
totalhealthcorrection.com

Patient Assessment Questionnaire

Name:_____ Date: _____

Address: _____ City/State: _____ Zip: _____

SSN: _____-_____-_____ Birth date: _____ Age: _____ M S W D

Phone 1: _____ Phone 2: _____ E-mail: _____

Is it okay to leave a voice message? (Circle one or all) Home Cell Work None

May we send you e-mail newsletters? Yes □ No □

How should we send you appointment reminders? □ Text: _____ □ E-mail

Occupation: _____ Employer: _____

Referred By: □ Friend □ Relative □ Advertisement □ Other _____

Which one of our patients should we thank for referring you? _____

Please list your health concerns in order of importance that you wish to address:

Concern	Date of Onset	What makes it better?	What makes it worse?	Severity (1 -10)

Other doctors seen for your complaint (s):

□ Chiropractic Care (D.C.) Were you satisfied? Yes □ No □ Name: _____

□ Medical Care (M.D.) Were you satisfied? Yes □ No □ Name: _____

□ Other Care Were you satisfied? Yes □ No □ Name: _____

Office Policies: *I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, that Total Health Correction Chiropractic will prepare the necessary reports and claims to assist me in reimbursement from the insurance company and that any amount authorized to be paid directly to Total Health Correction Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that no cures are promised and any risks regarding care will be explained to me. I now authorize Total Health Correction to proceed with necessary care and treatment.*

Patient Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Patient Name: _____

List all prescriptions, over-the-counter medications and herbal, homeopathic, hormonal, and nutritional (vitamins/minerals) supplements, you are **currently taking: (**Use back of page if more space is needed.)

Medication	Dose	Condition taken for	Time of day taken

Have you ever taken any of the following medications?:

Birth Control □ Antibiotic □ Antidepressant □ Hormones □ Antifungal □

Weight Loss □ Blood Pressure □ Cholesterol Lowering □ Anticoagulants □

Please list all allergies and sensitivities (food, environmental, and seasonal):

_____

Lifestyle

Alcohol: Never ___ Currently ___ Once/Wk __ 2-4 Times/Wk__ 3-5 Times/Wk__ More__

Tobacco: Cigarettes _____ Chewing Tobacco _____ Cigar _____ Pipe _____

Never ___ Currently ___ Per Day_____ Previously___ How Long Ago_____ Per Day_____

Dine Out: Never ___ Currently ___ Once/Wk __ 2-4 Times/Wk__ 3-5 Times/Wk__ More __

Exercise: Never ___ Currently ___ Once/Wk __ 2-4 Times/Wk__ 3-5 Times/Wk__ More __

Changed jobs: Within Last 2 Months_____ Last 6 Months_____ Last 12 Months_____

Divorced: Within Last 6 Months_____ Last 12 Months_____ Last 2 Years_____

Work over 60 hours/week: Always _____ Usually _____ Occasionally _____ Never_____

Diet

Read the following questions and fill in the number that applies:

Key: 0 = Do not consume/use 1 = Daily 2 = 2-3 times/month 3 = Weekly

___ Artificial sweeteners ___ Diet Often ___ Milk Products ___ Water, distilled

___ Candy or other sweets ___ Fried Foods ___ Non-herbal tea ___ Water, tap

___ Carbonated beverages ___ Luncheon Meats/Hot Dogs ___ Water, well

___ Coffee ___ Margarine ___ Refined sugar ___ Refined flour/baked goods

**** Female Patients **** Are you pregnant at this time? □ Yes □ No Due Date: _____

Hysterectomy: □ Full □ Partial Year: _____ Menopausal: □ Yes □ No Perimenopausal: □ Yes □ No

Family History

√ Mark the following conditions as they pertain to your immediate family.

	Mother	Father	Brother	Sister	Children
Diabetes					
Hypertension					
Heart Problems					
Kidney Problems					
Cancer					
Obesity					
Scoliosis					
Back Problems					
Osteoporosis					
Headaches					
Birth Defects					
Thyroid					
Smoker					
Anemia					

Surgical History

Please list all medical procedures and surgeries:

Surgery/Procedure	**Date**	**Reason for procedure**

Past Medical History

Which of the following conditions have you been diagnosed present or past?

√ Mark the following conditions

□ Abscesses	□ Tonsillitis	□ Goiter	□ Lactose Intolerant	□ Malaria
□ Diabetes	□ Peritonitis	□ Measles	□ Epilepsy/Seizures	□ Skin Disease
□ Heart Disease	□ Pleurisy	□ Kidney Disease	□ Warts	□ Stroke
□ Mumps	□ Chicken Pox	□ Worms/Parasites	□ Prostatitis	□ Gallstones
□ Asthma	□ Eating Disorder	□ Tuberculosis	□ Leukemia	□ Hepatitis
□ Pelvic Inflammatory	□ Rheumatic Fever	□ Mononucleosis	□ Typhoid Fever	□ Pneumonia
□ Cold Sores	□ HIV	□ Appendicitis	□ Venereal Disease	□ Psychiatric Disorder

□ High Blood Pressure □ Cancer (type): _____

List any other conditions the doctor should be aware of:

_____

_____

System Review

√ Mark the following conditions you are **currently** experiencing (past 30 days).

General

□ allergies	□ chills	□ convulsions	□ depression	□ bruise easily
□ loss of weight	□ fatigue	□ fever	□ hives	□ loss of sleep
□ weight gain	□ itching	□ night sweats	□ wheezing	□ nervousness

Gastrointestinal

□ constipation	□ diarrhea	□ vomiting blood	□ hemorrhoids	□ jaundice
□ liver problems	□ nausea	□ stomach pain	□ poor appetite	□ poor digestion
□ rectal bleeding	□ vomiting	□ gall bladder problems		

Eye/Ear/Nose/Throat

□ asthma	□ double vision	□ deafness	□ earache	□ ear discharge
□ ear noises	□ enlarged thyroid	□ frequent colds	□ hay fever	□ loss of smell
□ nasal obstruction	□ nose bleeds	□ pain in eyes	□ poor vision	□ sinusitis
□ tonsillitis	□ difficulty swallowing			

Respiratory

□ chest pain	□ chronic cough	□ spitting blood	□ spitting phlegm	□ difficulty breathing

Muscles/Joints/Bones

□ backache	□ foot problems	□ shoulder pain	□ hip pain	□ painful tailbone
□ deformity	□ swollen joints	□ knee pain	□ limping	□ weakness

Cardiovascular

□ ankle swelling	□ chest pain	□ coughing blood	□ weakness	□ high blood pressure
□ poor circulation	□ rapid heart	□ slow heart	□ shortness of breath	□ low blood pressure

Genitourinary

□ burning on urination	□ painful urination	□ recurrent bladder infection
□ increased urination at night	□ blood in urine	□ difficulty starting
□ increased urination at day	□ kidney stones	

Have you had laboratory testing completed in the past 12 months?	□ Yes	□ No
Will you provide a copy to Total Health Correction?	□ Yes	□ No

**** Weight Loss Patients****

What diets have you tried? What was the outcome?

_____

_____

Do you feel like you eat healthy?	□ Yes	□ No
Do you feel like you should be losing weight but are not?	□ Yes	□ No

What is your stress level? 1 = All is Well, 10 = Immediate Help Needed _____

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DISCLOSURE AND CONSENT TO CHIROPRACTIC SERVICES

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing potential risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various diagnostic tests, acupuncture or other related remedies on me (or the patient named below, for who I am legally responsible) by Dr. Chris Thoma, the Doctor of Chiropractic, and/or those working at the office who now or in the future treat me while employed by, working for or associated with, or serving as a backup for the doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, or other clinic personnel, my diagnosis, the nature and purpose of chiropractic adjustments and the plan of treatment or other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks and hazards to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or not improvement of symptoms or pain. I understand that the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; and that I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above Consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this Consent Form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

To be completed by the patient:

_____

Print Name

_____

Signature of Patient or Legal Guardian

_____

Date Signed

To be completed by doctor or staff:

_____

Witness to patient's signature

_____

Date Signed

DOCTOR'S NOTES: