



### **What to expect at your first appointment?**

At your first appointment you will have x-rays, scans and your first consultation. This appointment will take about an hour to complete. You will check in on the iPad at our front desk. The chiropractic assistant will ask for your insurance card and have you sign our HIPPA compliance form. Once you have completed that, our chiropractic assistant will take you back to the exam room and have thermal scan and a surface EMG scan. The thermal scan measures heat on each side of your spine. When subluxations are present, there can be a change in temperature from one side to the other (asymmetry), due to changes in blood supply. The surface EMG symmetry scan in addition to the amount surface electricity shown by the reading above, the symmetry of one side compared to the other is also important. A variation from one side to the other is a clear indication that subluxations are having an effect on your muscular system. Normal levels and symmetry are the goals for this reading. Next, she will take you into the x-ray room to complete x-rays. Next, Dr. Christine Gordon will come in and do a consultation and full examination. You will then come back out to schedule your next appointment.

### **What to expect at your second appointment?**

We call this appointment the Report Of Findings. This appointment will be about 45minutes to an hour. Once you come in the office, you will sign in on our iPad and check in. Dr. Christine will then bring you back into her office and she will go over the scans and x-rays with you and give you a detailed explanation of what she has found and a care plan. Next, our chiropractic assistant will come in and go over your insurance coverage and answer any insurance questions that you may have. Our chiropractic assistant will then have you lay on our traction table for 10 minutes before receiving your first adjustment. The traction table will massage the muscles along the spine to help bring nutrients to the spine. When the timer goes off, Dr Christine will take you through and discuss within your first adjustment! *Before you leave you will stop at the front desk to get all scheduled up and that is it!*

### **How Long Will You Continue Care?**

Many patients are under the false impression that if they go to a Chiropractor once, they must continue forever to continue feeling relief. This myth is commonly believed because those who experience chiropractic care feel so good that they want to stay that way and continue seeing their Chiropractor. It's Dr. Christine's goal that you'll get to a point where you only need to come monthly. We recommend maintenance treatments once a month or every couple of months to keep your mind and body in tune.

**ATTENTION: Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Gordon Chiropractic, reserves the right to charge a fee of \$50.00 for missed new patient consults without a 24-hour advance notice.**

**"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" may result in termination from our practice.**

**Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.**

**GORDON CHIROPRACTIC**

Family Health and Wellness Center

3212 N 13th St.

Terre Haute IN 47804

(812) 460-1400 Phone

www.gordon-chiro.com



**Please complete this application for care to help us determine if chiropractic care is right for you.**

**PERSONAL HISTORY**

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: M S W D Spouse's Name: \_\_\_\_\_ Spouses DOB: \_\_\_\_\_

# of Children: \_\_\_\_\_ Name of Primary Care Physician: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you previously been seen by a Chiropractor?  Yes  No Who/When? \_\_\_\_\_

How did you hear about our office? (circle one) Friend or Family Facebook Website TV Radio Phone Book Other

Please name the person who referred you so that we may thank them: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I certified that I, and/or my dependent(s), have insurance coverage and assign directly to Gordon Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Any outstanding balances over 90 days are subject to being turned over to Professional Accounts Service, INC and will be charged at 40% collection fee in addition to the balance due.

I authorize the use of my signature on all insurance submissions. I further authorized Gordon Chiropractic to use my healthcare information and disclose information to your insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I am also informed at this time I have the right to withdraw my name from this signature on file agreement at any time when I have notified this office in writing. In the case that the patient is a minor I as the guardian am stating that I agree for Gordon Chiropractic to provide all services of care to my minor child/children.

Patient/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Throughout life, stressed and traumatic events can damage the spine and nervous system. These stresses may be PHYSICAL, CHEMICAL, and/or EMOTIONAL in nature. Understanding the stresses that have acted upon your spine and nervous assists us in serving you.

### HISTORY OF PHYSICAL STRESS

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Have you EVER had any accidents related to the following: (check all that apply, explain and give dates)

Auto       Motorcycle       Bicycle       Sports       Other: If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Have you EVER been in a fender bender or minor car accident?    Yes    No    Please list date(s): \_\_\_\_\_  
\_\_\_\_\_

Have you ever injured your nerve system or spine (head, neck, back, hips, pelvis)    Yes    No    If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Have you broken any bones?    Yes    No                      Sprained any part of the body?    Yes    No  
If yes, location, date, and how: \_\_\_\_\_

Surgical history: \_\_\_\_\_

Hospitalization history: \_\_\_\_\_

Hobbies or interests: \_\_\_\_\_      Daily/Work activities (circle):    sit    stand    lift    bend    twist

Do you exercise?    Yes    No                      Type/frequency: \_\_\_\_\_

### HISTORY OF CHEMICAL STRESS

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Chemical stresses occur during life due to any substance that is inhaled, injected, taken orally, or placed on the skin that is toxic to the body. The following will give us insight into any exposure you might have had or currently have.

Have you EVER used prescription or recreational drugs or been vaccinated?    Yes    No

List all medication (prescription and over the counter) and vitamins you take and why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FEMALES:** Pill or Patch Use?       Yes, currently for the last \_\_\_\_\_ years       No, but previously for \_\_\_\_\_ year       Never

**SMOKER?**    Never       Yes, currently       Yes, previously, but quit \_\_\_\_\_ (date)      Packs per day? \_\_\_\_\_

How many servings of fresh fruits/vegetables do you eat in a typical day? \_\_\_\_\_      Caffeine? \_\_\_\_\_ cup/day

How many glasses of water do you drink each day? \_\_\_\_\_

## HISTORY OF EMOTIONAL STRESS

It is difficult to separate the emotional stress in our lives from the physical response that often occurs.

Please indicate if you have ever experienced any emotional/mental stress from the following categories:

Childhood trauma, illness, family stress, lifestyle change, parental divorce, work or school, relationships, financial, abuse (physical or emotional), loss of loved one, other stress?     Yes, a few     Yes, many     No

Do you practice meditation, prayer or other stress reducing activity on a regular basis?     Yes     No

Sleep quality:     Poor     Fair     Good     Excellent

## FAMILY HISTORY

Please note any health problems that are present in:

MOTHERS FAMILY:	<input type="checkbox"/> Heart disease	<input type="checkbox"/> High BP	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anxiety/Depression
FATHERS FAMILY:	<input type="checkbox"/> Heart disease	<input type="checkbox"/> High BP	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anxiety/Depression
SIBLINGS:	<input type="checkbox"/> Heart disease	<input type="checkbox"/> High BP	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anxiety/Depression

List any other diseases that "run in your family": \_\_\_\_\_

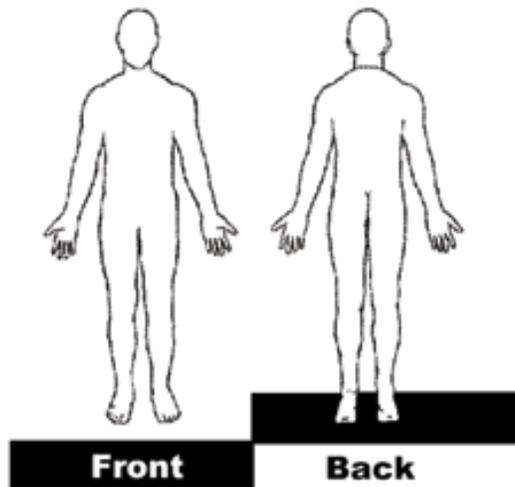
Doctor's use only: \_\_\_\_\_  
\_\_\_\_\_

## CURRENT HEALTH/PRIMARY COMPLIANT

What is your primary health challenge? \_\_\_\_\_

Began: \_\_\_\_\_ Previously occurred: \_\_\_\_\_

On the diagram to the right please indicate any specific area(s) of health concern. Please circle area of chief complaint or health challenge.



## HEALTH AND WELLNESS GOALS

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Today we are here to discover your goals and priorities as it relates to your health and wellness. Your answers will help us determine how we can best help you.

Are you healthier today than you were 5 years ago?     Yes     No

If "yes", what did you do to improve your health? \_\_\_\_\_

If "no", why do you think your health is declining? \_\_\_\_\_

Will you be healthier 5 years from now than you are today?     Yes     No

If so, what are you planning on doing to improve your health and if not, what could you do to improve your health rather than have it continue to decline? \_\_\_\_\_

What would you like your health to be 5 years from now? \_\_\_\_\_

Check the box next to any area of health and wellness that is important to you:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> More energy                    | <input type="checkbox"/> Better sleep                          | <input type="checkbox"/> Freedom from pain               |
| <input type="checkbox"/> Better concentration           | <input type="checkbox"/> Enhanced emotional well-being         | <input type="checkbox"/> Reduce/eliminate medication use |
| <input type="checkbox"/> Improve digestion              | <input type="checkbox"/> Improved strength and endurance       | <input type="checkbox"/> Greater resistance to disease   |
| <input type="checkbox"/> Easier/deeper breathing        | <input type="checkbox"/> Better sports reaction time, reflexes | <input type="checkbox"/> Overall health improvement      |
| <input type="checkbox"/> Deeper relaxation              | <input type="checkbox"/> Other: _____                          |  |
| <input type="checkbox"/> More balanced/improved posture |  |  |

What are your top 3 health and wellness goals?

1) \_\_\_\_\_    2) \_\_\_\_\_    3) \_\_\_\_\_

## FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage every day activities. For each item below, please "X" on the number which most closely describes your condition right now, and then circle were you would like to be.

**X** = current condition

○ = desired outcome

### 1. Pain Intensity

No Pain	Mild Pain	Moderate Pain	Severe Pain	Horrific Pain
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### 2. Sleeping

Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep
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### 3. Personal Care (washing, dressing, etc.)

No Pain, No Restrictions	Mild Pain, No Restrictions	Moderate Pain, Need to go Slowly	Moderate Pain, Need Some Assistance	Severe Pain, Need 100% Help
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### 4. Travel (driving, etc.)

No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain, On Long Trips	Moderate Pain, On Short Trips	Severe Pain, On Short Trips
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### 5. Work

Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
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### 6. Recreation

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
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### 7. Frequency of Pain

No Pain	Occasional Pain; 25% of the day	Intermittent Pain; 50% of the day	Frequent Pain; 75% of the day	Constant Pain; 100% of the day
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### 8. Lifting

No Pain with heavy weight	Increased Pain with heavy weight	Increased Pain with moderate weight	Increased Pain with light weight	Increased Pain, with any weight
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### 9. Walking

No Pain at any distance	Increased Pain after 1 mile	Increased Pain after ½ mile	Increased Pain after ¼ mile	Increased Pain with all walking
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### 10. Standing

No Pain after several hours	Increased Pain after several hours	Increased Pain after 1 hour	Increased Pain after 30 minutes	Increased Pain with any standing
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### 11. Sitting

No Pain after several hours	Increased Pain after several hours	Increased Pain after 1 hour	Increased Pain after 30 minutes	Increased Pain with any sitting
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# REVIEW OF SYSTEMS

## NERVOUS SYSTEM

Past Problem	Current Problem	
<input type="checkbox"/>	<input type="checkbox"/>	Headache/Migraine
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis/Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy

I DENY all systems listed below in Nervous System

Past Problem	Current Problem	Past Problem	Current Problem
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Doctor's Use Only**

## MUSCLES & JOINTS

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Back problems
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain/stiff
<input type="checkbox"/>	<input type="checkbox"/>	Painful/stiff Joints
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis

I DENY all systems listed below in Muscle & Joints

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## RESPIRATORY

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy

I DENY all systems listed below in Respiratory

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## EENT, SKIN, ALLERGIES

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Glasses or Contacts
<input type="checkbox"/>	<input type="checkbox"/>	Speech difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis

I DENY all systems listed below in EENT, Skin, Allergies

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## G-I/ENDOCRINE

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion

I DENY all systems listed below in G-I/Endocrine

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## CARDIO-VASCULAR

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Easily Bruised
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins

I DENY all systems listed below in Cardio Vascular

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## GENITO-URINARY

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection

I DENY all systems listed below in Genito-Urinary

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## GENERAL

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Chills/Sweats
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Other Not Listed: _____	

I DENY all systems listed below in General

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## FEMALES ONLY

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Backache with Period
<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle

I DENY all systems listed below in Females Only

Past	Current	Past	Current
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Last Period: \_\_\_\_\_  
 Pregnant: yes no EDD \_\_\_\_\_  
 Number of Pregnancies: \_\_\_\_\_  
 Number of Live Births: \_\_\_\_\_