Patient History

Welcome to Advanced Alternative Medicine Center. We appreciate the trust you have placed in us to work together with you to regain and maintain your health. We pride ourselves in our commitment to our patients. We look after each patient as we would the closest member of our family.

Being healthy is a lifetime commitment. It requires that a person make decisions that are constructive to ones body. Just as a person takes their car in for a tune-up when it is running well to keep it that way, we believe your body should have a Health Care "tune-up" on a regular basis to keep your body operating at its highest level possible.

As a Doctor of Chiropractic, I am often incorrectly thought to be a "back doctor." However, I am a doctor who helps the body to heal itself, without drugs, by balancing the nervous system, removing stress and promoting normal function. I work with you, not on you.

My own personal philosophy is to treat the body as a whole, rather than just a bunch of individual parts. My experience and vast amounts of continuous training in Alternative Health Care methods helps me to treat the body as a whole. Through education and understanding I hope to give you the knowledge you will need to improve your health to an optimal level. It is vitally important that you take an active role in discussing with me ALL your questions and concerns.

We look forward to a long and positive relationship with you. Please consider us your family's Total Health Care Office and do not hesitate to ask us how we can be of help in any and all circumstances regarding your health, and the health of your family members.

Yours for Better Health, Naturally;

Dr. Richard A. Huntoon

Most patients who come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Dr. Huntoon will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Check the type of care desired so that we may be guided by your wishes whenever possible.

❑ Relief Care ❑ Corrective Care

❑ Check here if you want the doctor to select the type of care appropriate for your condition

Patient's Signature:_____ Date:_____

Confidential Patient Health Record

Personal History

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Home phone: _____ Birth date: _____ Age: _____ Sex: ❑ M ❑ F

Social Security: _____ Drivers license number: _____

Business employer: _____ ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Business phone: _____ Type of work: _____

Name of spouse: _____ Spouse's Social Security #: _____

Spouses employer: _____ Spouse's type of work: _____

Referred to this office by: _____ Name and ages of children: _____

Name of emergency contact: _____

Number of emergency contact: _____ Relationship: _____

Current Health Condition

Unwanted health condition: _____

Other Doctors seen for this condition: ❑ Yes ❑ No Who? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? Yes ❑ No ❑

Is condition: ❑ Job Related ❑ Auto Accident ❑ Home Injury ❑ Fall ❑ Other:

Date of accident: _____ Time of accident: _____ Have you made a report of your accident to your employer: ❑ Yes ❑ No

Drugs you now take: ❑ Nerve Pills ❑ Pain Killers/Muscle Relaxers ❑ Blood Pressure Medicine ❑ Insulin ❑ Other Do you wear orthotics? ❑ Yes ❑ No

Do you suffer from any condition other than that which you are now consulting us? _____

_____

Past Health History

Please check and describe:

❑ Major Surgery/Operations ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia ❑ Back Surgery ❑ Broken Bones ❑ Other

Major accident or falls: _____

_____

Hospitalization (other than above): _____

_____

Previous chiropractic care: ❑ None ❑ Doctor's Name & Approximate Date of Last Visit: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

❑ Pneumonia
❑ Mumps
❑ Influenza
❑ Arthritis
❑ Small Pox
❑ Rheumatic Fever
❑ Pleurisy
❑ Epilepsy
❑ Polio
❑ Chicken Pox
❑ Tuberculosis
❑ Diabetes
❑ Cancer
❑ Whooping Cough
❑ Mental Disorders
❑ Anemia
❑ Measles
❑ Heart Disease
❑ Lumbago
❑ Thyroid
❑ Eczema
❑ Lyme Disease

Intake

❑ Coffee
❑ Tea
❑ Alcohol
❑ Cigarettes
❑ White Sugar

Have you ever been tested positive for HIV? ❑ Yes ❑ No

Check any of the following diseases you have had in the PAST 6 MONTHS:

Musculo-Skeletal

❑ Low Back Pain
❑ Pain Between Shoulders
❑ Neck Pain
❑ Arm Pain
❑ Joint Pain/Stiffness
❑ Walking Problems
❑ Difficult Chewing/Clicking Jaw
❑ General Stiffness

Nervous System

❑ Nervousness
❑ Numbness
❑ Paralysis
❑ Dizziness
❑ Forgetfulness
❑ Confusion/Depression
❑ Fainting
❑ Convulsions
❑ Cold/Tingling Extremities
❑ Stress

General

❑ Fatigue
❑ Allergies: seasonal/food
❑ Loss of Sleep
❑ Fever
❑ Headaches

Genito-Urinary

❑ Bladder Trouble
❑ Painful/Excessive Urination
❑ Discolored Urine

Gastro Intestinal

❑ Poor/Excessive Appetite
❑ Excessive Thirst
❑ Frequent Nausea
❑ Vomiting
❑ Diarrhea
❑ Constipation
❑ Hemorrhoids
❑ Liver Problems
❑ Gall Bladder Problems
❑ Weight Trouble
❑ Abdominal Cramps
❑ Hiatal Hernia
❑ Gas/Bloating After Meals
❑ Heartburn
❑ Black/Bloody Stool
❑ Colitis/Bowel Inflammation

C-V-R

❑ Chest Pain
❑ Short Breath
❑ Blood Pressure Problems
❑ Irregular Heartbeat
❑ Heart Problems
❑ Lung Problems/Congestion
❑ Varicose Veins
❑ Ankle Swelling
❑ Stroke

EENT

❑ Vision Problems
❑ Dental Problems
❑ Sore Throat
❑ Ear Aches
❑ Hearing Difficulty
❑ Stuffed Nose

Male

❑ Prostate/Sexual Dysfunction

Female

When was your last period?_____

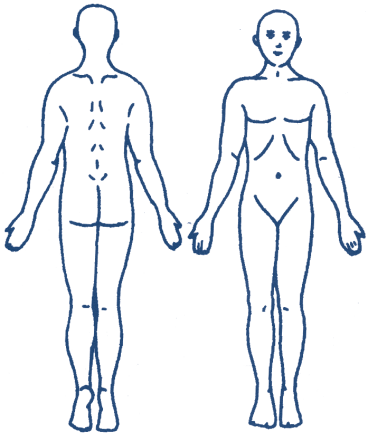
Are you pregnant?
❑ Yes ❑ No ❑ Not Sure

❑ Menstrual Irregularity
❑ Menstrual Cramps
❒ Vaginal Pain/Infection
❑ Breast Pain/Lumps
❑ Other Problems _____

Family History

The following members have a same or similar problem as I do:

❑ Mother
❑ Father
❑ Brother
❑ Sister
❑ Spouse
❑ Child



Please outline on the diagram the area of your discomfort

Patient History

Treatment recommendations are not designed based on insurance coverage but rather on what you need.

Our office will be happy to provide you with a receipt that you can submit to your insurance company.

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 for a fee of $50.00 and that any 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 treatment, any fees for professional service rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate. It is understood and agreed the amount paid the Doctor, is for examination only and the information will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of authorizing care: _____ Date: _____

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