

PATIENT HEALTH RECORD

Welcome to Providence Chiropractic Center. We are delighted and honored that you have chosen our office for your Chiropractic care. In order to help us understand your health history and better assess your present health status, please complete the following confidential information to the best of your ability. If you have any questions, we will be happy to assist you. In addition to completing this health record, you will receive a thorough consultation about your health history and your spine will be examined to help us determine how we may best serve you. The testing is painless and will reveal where your body may need attention. We are most concerned with assisting you to live a healthy and long life.

Our focus is making sure that we provide you with the care you desire, and often this is pain relief. We also are experts in longevity and hope that you will see that Chiropractic can assist you to live longer, healthier and more independently. We will advise you on how to get your ESS In Shape™ (Endurance, Strength, and Structure). If you are interested in living a long and healthy life, we will suggest you buy a manual, The 100 Year Lifestyle Workout Book, written by international best selling author, Dr. Eric Plasker. In it, you will learn how the health experts and elite athletes of the world take care of their bodies for maximum performance, endurance and longevity. We will coach you through the phases of getting your ESS In Shape™ as part of our services to you.

About You

Name _____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Birth Date _____ Age _____
Gender M F Number of Kids _____
Employer _____
Work Address _____
Work Phone _____
Type of Work _____
Email address _____
Marital Status (circle one) Married Single
Social Security # _____ Driver's License # _____
Your Family Doctor's Name: _____ May we send him/her a report of our findings? Y N

About the Spouse or Parent

Name _____ Relationship: _____
Employer _____ Type of Work _____
Work Phone _____
Emergency Contact (if other than above) _____ Phone _____
Does the spouse or parent have any health concern of their own that they may help with? Y N If so, what is that concern: _____

Medications I Now Take

Y is Yes N is No

Y N Nerve pills	Y N Insulin
Y N Pain Killers (including aspirin)	Y N Blood Pressure Medicine
Y N Muscle Relaxers	Y N Blood Thinners
Y N Tranquilizers	Others _____
	Others _____

Has your Medical Doctor spoken to you about the side effects and possible health hazards of the drugs you are now taking? Y N
 If no, would you like to learn more about the drugs you are taking? Y N

Health Habits

Do you smoke?	N	Y	# packs per day = _____
Do you drink alcohol?	N	Y	# drinks per day = _____
Do you drink coffee?	N	Y	# cups per day = _____
Do you exercise regularly? (circle one)	N	Moderate	Daily
What kind of endurance exercise do you perform? _____		How long? _____	
What kind of strength training do you perform? _____			
Do you eat 5-13 portions of vine-ripened fruits and vegetables every day? (circle one) N Y If not, how many? _____			
How many hours do you sleep nightly? _____ Do you feel rested upon awakening after sleeping? (circle one)			N Y
Do you drink 64 ounces of water/fluids daily? (circle one) N Y If not, how many ounces do you drink? _____			

Family Health History

Is there anyone in your family who experiences or has experienced (please indicate who):

Arthritic conditions: _____

High blood pressure, heart disease, stroke: _____

Cancer: _____

Diabetes: _____

Genetic Diseases: _____

Is Your Mother Alive? Y N If yes, how old? _____ If no, how old was she when she passed? _____ What did she die from? _____

Is Your Father Alive? Y N If yes, how old? _____ If no, how old was he when he passed? _____ What did he die from? _____

Are your Mom's parents alive? GM GF If yes, how old are they? _____
 If no, how old was/were they when they passed? _____ What caused their death? _____

Are your Dad's parents alive? GM GF If yes, how old are they? _____
 If no, how old was/were they when they passed? _____ What caused their death? _____

Did you know that you are more than your genetics? Your parents' and grandparents' life spans may not dictate how long or how well you will live. It turns out that your lifestyle choices are more important than your genetics. We can help you make better choices. Ask us how. A great resource is the book entitled "The 100 Year Lifestyle" by Dr. Eric Plasker, available on Amazon and at bookstores.

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of the pain and others for the correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Whatever you choose, we will support you in your decision. Please check the type of care desired so that we may be guided by your wishes whenever possible:

- Initial Intensive Care - Symptomatic relief of pain or discomfort
 Corrective Care - Correcting and relieving the cause of the problem, as well as the symptoms
 Comprehensive/Life Enhancement Care - We will assist you in getting your ESS In Shape™.
 I want the Doctor to select the type of care appropriate for my condition

Your health and longevity depend on having balance in all areas of your life... physical, nutrition, emotional, spiritual, relationships, and finance. We have resources available for you to maximize your balance. Please feel free to discuss these areas with us. We will provide the appropriate referrals if you are interested. We want you to succeed in living a long, healthy and independent life. As you age, it is even more important to get your ESS In Shape™ (Endurance, Strength and Structure).

Authorization For Care

I hereby authorize the Doctor to work with my condition through the use of Chiropractic adjustments to my spine, as he or she deems necessary. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am 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. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's Signature

Date

Guardian or Spouse's Signature Authorizing Care

Date

Our Promise:

Is to honestly and thoroughly evaluate your spine and provide you with enough information so that you can make great decisions about your health and life.

Thank you for completing this health questionnaire. We hope that this will be the beginning of a long and mutually beneficial relationship in which our office will provide first rate service to you, your family and your friends. If we have met or exceeded your expectations, please feel free to share your experience with others so that they, too, may benefit from Chiropractic care. If not, please let us know how we may better serve you.


Dr. Jack M. Bourla, D.C., Q.M.E.

Providence Chiropractic Center

499 Seaport Court, Suite 101, Redwood City, CA 94063 (650) 365-1473

Initial Consultation

1. Your Name: _____ Date: _____

2. What area(s) of your body is/are troubling you? _____

3. When did this trouble begin? _____

4. What were you doing at the time that this trouble began? _____

5. Is there anything that you do that makes this trouble feel better (*please circle all that apply*)

Stretching Rest Over the counter medication Prescription medication
Ice Heat Massage Changing positions frequently Laying down
Walking Sitting Others _____

6. Is there anything that you do that makes this trouble feel worse (*please circle all that apply*)

Sitting Walking Lifting (how much?) Sneezing/Coughing
Standing Looking up or down Looking sideways Climbing Stairs
Others _____

7. What does your pain feel like (*please circle all that apply*)?

Sharp Dull Stabbing Burning Throbbing Achy Other

8. Does your pain go **anywhere** else in your body? _____

9. Overall **FREQUENCY** of complaint (please circle one)

Constant (100% of time) **Frequent** (75%) **Intermittent** (50%) **Occasional** (25%)

10. Overall **INTENSITY** of complaint (please circle one)

Minimal (an annoyance but has no effect on activities)

Slight (tolerable with some impairment of activities)

Moderate (tolerable with marked impairment on activities)

Severe (intolerable and cannot perform activities)

11. Please list any activities that you feel you cannot perform due to your condition (including sleep): _____

Your Signature

Date

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Professional Fee For Service

Initial Consultation and Comprehensive Orthopedic/Neurological Exam.....	\$65-95
Re-exam/Brief Office Visit.....	\$25-55
Basic Office Visit (minimum office charge for adjustment).....	60
Therapeutic Massage (one and one half hours).....	135
Therapeutic Massage (one hour).....	95
Therapeutic Massage (half hour).....	45
House Calls, After Hours Emergency Visit.....	100 and up
Natural Calm (16 oz).....	38
Glucosamine/Chondroitin/MSM (240 capsules).....	82
JuicePlus (four month supply, delivered to your door).....	168

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your chiropractic care and you may choose the plan you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being and we will do our best to serve you.

Regarding Insurance: We are not Participating Providers for any insurance companies, and we are not part of any HMOs. We do not participate in MEDICARE. We will, in some cases, bill your insurance for you and accept assignment of your benefits (this means we bill the insurance carrier, they pay us directly, and we will bill you for any remaining balance). For other cases, we will bill your insurance on your behalf and collect payment from you at the time of the service and you will be responsible for following up with your insurance. We bill insurances as a convenience to you. We do not bill secondary insurances. We are able to keep our prices competitive because we do not have a billing staff that has to track down insurance claims.

Agreement: My signature below signifies my understanding that I am personally responsible for the payment of all care rendered to me by Dr. Bourla and his staff/associates, regardless of whether or not I have insurance. If I receive a bill from Dr. Bourla, I agree to pay it in full within 10 days of receiving it, unless other arrangements have been agreed to, in writing, by all parties.

I have read and agree to the above fee statement:

Patient's Printed Name

Patient's Signature

Date

Witness