TO THE NEW PATIENT
OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:
A consultation with the doctor to discuss your health problems and to determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation, including those tests necessary to determine the precise cause of your problem.

STEP FOUR:
The doctor will advise you if additional laboratory tests or other tests including x-rays are needed.

STEP FIVE:
You will be given a Report of Findings at which time the cause of your problem will be discussed. You will be given a thorough explanation of how chiropractic works and how results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:
If you are accepted as a patient, chiropractic care will begin. The type of care you need will be explained to you. Also, additional explanations will be given on the different types of care available in the office.

STEP SEVEN:
An estimate of the future care that is needed will be given and, upon your acceptance, adjustments will begin and continue until a maximum correction for you has been obtained.

STEP EIGHT:
After maximum correction, a schedule of care will be recommended to help prevent future problems and maintain good health.

Date:	ID No.

Confidential Patient Health Record

PERSONAL HISTORY

Name: _____	Address: _____
City: _____	State: _____ Zip: _____
Home Phone: _____	Birth Date: _____ Age: ____ Sex: M/F
Cell Phone: _____	Driver's License #: _____
Social Security #: _____	Married Single Widowed Divorced Separated
Business Employer: _____	Type of Work: _____
Business Phone: _____	Email Address:_____
Name of Spouse: _____	Spouse's SSN: _____
Spouse's Employer: _____	Spouse's Bus. Phone: _____
Spouse's Type of Work: _____	Referred By: _____
Emergency Contact: _____	Relationship: _____
Contact Phone: _____	
Who is Responsible For Your Bill:	
□ Spouse □ Workers' Comp □ Auto Insurance	□ Medicare □ Medicaid
□ Health Ins (Name): _____	□ Health Card #: _____

Date:	ID No.

Confidential Patient Health Record

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

Other Doctors seen for this condition: _____

Type of Treatment: _____ Results: _____

Has this condition occurred before/when did it begin? _____

Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other _____

Date/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 Medication

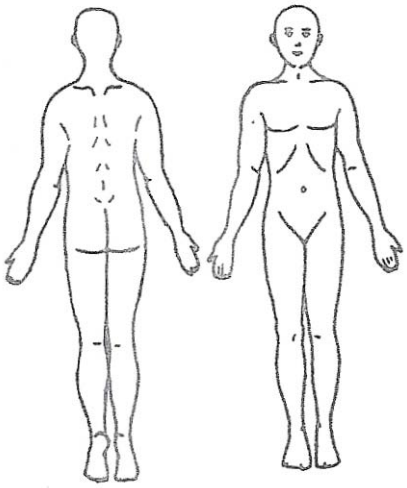
□ Insulin □ Other _____

Do You Wear a Shoe Lift? □ Yes □ No

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

_____

Please outline on the diagram the area of your discomfort



Date:	ID No.

Confidential Patient Health Record

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □Gall Bladder □ Hernia □ Back Surgery

□ Broken Bones □ Other _____

Major Accidents or Falls: _____

_____

Hospitalization (other than above): _____

_____

Previous Chiropractic Care: □ None □ Doctor's Name and Approximate Date of Last Visit

_____

Below is 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 chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

□ Pneumonia	□ Mumps	□ Influenza	**INTAKE**
□ Rheumatic Fever	□ Small Pox	□ Pleurisy	□ Coffee
□ Polio	□ Chicken Pox	□ Arthritis	□ Tea
□ Tuberculosis	□ Diabetes	□ Epilepsy	□ Alcohol
□ Whooping Cough	□ Cancer	□ Mental Disorders	□ Cigarettes
□ Anemia	□ Heart Disease	□ Lumbago	□ White Sugar
□ Measles	□ Thyroid	□ Eczema	

Have you been tested HIV positive? □ Yes □ No

Date:	ID No.

Confidential Patient Health Record

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE	**GASTRO-INTESTINAL CODE**	**MALE/FEMALE CODE**
□ Low Back Pain	□ Poor/Excessive Appetite	□ Menstrual Irregularity
□ Pain Between Shoulders	□ Excessive Thirst	□ Menstrual Cramps
□ Neck Pain	□ Frequent Nausea	□ Vaginal Pain/Infection
□ Arm Pain	□ Vomiting	□ Breast Pain/Lumps
□ Joint Pain/Stiffness	□ Diarrhea	□Prostate/Sexual Dysfunction
□ Walking Problems	□ Constipation	□ Other Problems
□ Difficult Chewing/Clicking Jaw	□ Hemorrhoids	□
□ General Stiffness	□ Liver Problems	
	□ Gall Bladder Problems	
NERVOUS SYSTEM CODE	□ Weight Trouble	
□ Nervous	□ Abdominal Cramps	
□ Numbness	□ Gas/Bloating After Meals	
□ Paralysis	□ Heartburn	
□ Dizziness	□ Black/Bloody Stool	
□ Forgetfulness	□ Colitis	
□ Confusion/Depression		
□ Fainting	**C-V-R CODE**	
□ Convulsions	□ Chest Pain	
□ Cold/Tingling Extremities	□ Short Breath	**FAMILY HISTORY**
□ Stress	□ Blood Pressure Problems	The following members have a similar problem as I do:
	□ Irregular Heartbeat	□ Mother
GENERAL CODE	□ Heart Problems	□ Father
□ Fatigue	□ Lung Problems/Congestion	□ Brother
□ Allergies	□ Varicose Veins	□ Sister
□ Loss of Sleep	□ Ankle Swelling	□ Spouse
□ Fever	□ Stroke	□ Child
□ Headaches		
	EENT CODE	
GENITO-URINARY CODE	□ Vision Problems	
□ Bladder Trouble	□ Dental Problems	
□ Painful/Excessive Urination	□ Sore Throat	
□ Discolored Urine	□ Ear Aches	
	□ Hearing Difficulty	
	□ Stuffed Nose	

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted: □ Yes □ No □ Referred

_____

Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go 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). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please 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

_____ _____

Date Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

RELIEF CARE	**CORRECTIVE 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 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.

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 and that any amount authorized to be paid directly to the Doctor's Office 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 that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through use of adjustment throughout my spine. It is understood and agreed the amount paid the Doctor, is for examination and x-rays only. The X-ray negatives 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. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature
Authorizing Care _____ Date _____

Cooperstown Chiropractic
680 Langsdorf Drive, Suite 101
Fullerton, CA 92831
(714) 525- 8700
admin@cooperstownchiro.com
DrCooper@cooperstownchiro.com

To our patients,

We ask that you read and sign this form in regards to HIPAA (Health Insurance Portability and Accountability Act).

In our center, we have an open-adjusting area as well as private consultation rooms. You will always have the right to choose where you would like your adjustment to take place. When you are in an open forum, it is obvious that, at times, your adjustment or discussions may be overheard by someone else. For private discussions, we will always be as discreet as possible, but it is your right to choose a private room versus the open bay.

One of the reasons for an open-adjusting environment is for efficiency and another is for your education and enlightenment. The open-adjusting environment will provide you with a greater understanding of common health care concerns, chiropractic care in general and types of patients that seek chiropractic care.

Your signature is required by the Federal HIPAA laws, indicating that you have read, understood and are in agreement with our open-adjusting environment, in which some incidental details of your care may be disclosed and other may hear or see details about your care.

Patient/Guardian:

_____/_____

(Print) (Signature)

Date: _____

Witness:

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admin@cooperstownchiro.com
DrCooper@cooperstownchiro.com

Office Fee Schedule and Financial Policy

Service	
CONSULTATION	**No Charge**
EXAMINATION	**$90 - $250**
RE-EXAMINATIONS	**$90 - $150**
X-RAYS (per view)	**$35 - $150**
ADJUSTMENT	**$65 - $95**
WELLNESS ADJUSTMENT PLANS	**$249 - $331 mo.**
DETOXIFICATION	**$211 (prices may vary)**
PHYSIO-THERAPY	**$20 - $45**
CRANIAL SACRAL TECHNIQUE –UNWINDING	**$90 per hour**
ORTHOTICS	**$100 + COST OF CUSTOM ORTHOTIC**
MISSED APPOINTMENTS	**$45**

Financial Policy and Chiropractic Wellness Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange a Wellness Plan in advance. Wellness Plans include yearly Corrective Care Adjustment Plans, monthly Corrective Care Plans, Wellness Plans including Family Wellness Plans or extended payment plans. These Wellness Plans are designed to be the most cost-effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

You may have the situation where a Wellness Plan has to be discontinued. As you have that right, there is a $250 cancellation fee that will apply.

If you are like most of our patients and choose to participate in one of our Wellness Plans, there is a possibility that we may file your insurance for you. We will discuss this option with you during your Chiropractic Report.

If you have a special situation such as an auto accident or a worker's compensation injury and choose to utilize that coverage, you will be charged reasonable and customary fees for those cases. If you choose not to use that insurance, you will be charged our regular office fees until such claim is settled. We will help you get reimbursed quickly on these claims. Once the claim is complete, you can resume your Corrective or Wellness Plan.

I have read and I understand the above policies.

_____

Patient Signature Date

Cooperstown Chiropractic
680 Langsdorf Drive, Suite 101
Fullerton, CA 92831
714-525-8700
DrCooper@cooperstownchiro.com

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only methods are to identify and remove the stressors that prevent you from functioning properly.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Dr. Ken Cooper
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(714) 525-8700
DrCooper@cooperstownchiro.com

INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

Patient's Name: _____

I hereby request and consent to the performance of procedures which are within the scope of practice of chiropractic including, but not limited, to chiropractic adjustments, various modes of physical therapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above and /or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand and I am informed that there are some risks to chiropractic treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my condition.

_____ _____
Signature of Patient or Patient's Representative Print Name of Patient's Representative

_____ _____
Witness to Patient's Signature Date Doctor Verbally Addressed Consent

_____
Translated by Date Date

Cooperstown Chiropractic
680 Langsdorf Drive, Suite 101
Fullerton, CA 92831
714-525-8700
admin@cooperstownchiro.com

Permission to Use Photograph Subject: _____

Location: Fullerton, CA

I grant to Cooperstown Chiropractic, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize Cooperstown Chiropractic, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Cooperstown Chiropractic, may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature _____

Printed name _____

Date _____

Signature, parent or guardian _____ (if under age 18)

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DrCooper@CooperstownChiro.com

ASSIGNMENT OF BENEFITS

To: _____ Insurance Co.

RE: Patient:
_____

Insured: _____

Employer: _____

Social Security No.: _____

Date of Birth: _____

I hereby demand that any and all payments by your company as result of treatment rendered by Cooperstown Chiropractic be made payable to the aforementioned clinic, and forwarded directly to the same. Payment shall NOT be sent to either me or any attorney that I may choose to represent me in this claim. This assignment shall be irrevocable unless released in writing by the antecedent clinic.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

I hereby authorize the aforementioned doctor to release any information acquired in the course of my examination or treatment. I further agree that a photographic authorization shall be as valid as the original.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is anyway we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#: _____
Address: _____ City: _____
State: _____ Zip: _____ e-mail: _____ Home Phone: _____
Birth Date: ____/____/____ Work Phone: _____Cell Phone: _____
Sex: _____ Weight: _____ Height: _____ Referred By: _____
Names of Parents / Guardians: _____

Purpose For Contacting Us? _____
Other Doctors Seen for this Condition: ___N___Y, Doctors' Names and Prior Treatments: _____
_____
_____
Other Health Problems? _____
Check any of the Following Conditions Your Child has suffered from During the Past Six Months:

___Ear Infections	____Scoliosis	____Seizures	____Chronic Colds	____Headaches
___Asthma / Allergies	____Digestive Problem	____ADHD	____Recurring Fevers	____Growing / Back Pains
___Colic	____Bed Wetting	____Car Accident	____Temper Tantrums	Other: _____

Family History: _____

Previous Chiropractor: _____
Date of Last Visit: ____/____/____ Reason: _____

Name Of Pediatrician: _____
Date Of Last Visit: ____/____/____ Reason: _____
_____
Are You Satisfied With The Care Your Child Received There? ____N____Y

Number Of Doses Of <u>Antibiotics</u> Your Child Has Taken:
During The Past Six Months: _____, Total During His or Her Lifetime: _____

Number Of Doses Of Other Prescription Medications Your Child Has Taken:
During The Past Six Months: _____, Total During His Or Her Lifetime: _____
List: _____

Vaccination: _____

Prenatal History:
Name of Obstetrician / Midwife: _____
Complications During Pregnancy? ___N___Y, List: _____

Ultrasound During Pregnancy? _____N_____Y, Number Of Ultrasounds: _____
Medications During Pregnancy / Delivery? _____N_____Y, List: _____
Cigarette / Alcohol Use during Pregnancy: _____N_____Y Location of Birth: _____
Hospital _____Birthing Center _____Home _____N _____ Y
Birth Intervention: _____ Forceps _____ Vacuum Extraction _____Caesarian Section, Emergency or Planned?
Complications During Delivery? _____N_____Y, List: _____
Genetic Disorders Or Disabilities: _____N_____Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History:

Breast Fed: ___N___Y, How Long: _____
Formula Fed: ___N___Y, How Long: _____ Type: _____
Introduced Solids at: _____ Months, Cows' Milk at_____ Months
Food / Juice Allergies or Intolerences: ___N___Y, List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to?

_____Respond to sound _____Cross Crawl
_____Respond to Visual Stimuli _____Stand Alone
_____Hold Head Up _____Walk Alone
_____Sit Up

According to the National Saftey Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, ect.). Was this the case with your child?___N___Y

Is or has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, ect.)_____N_____Y , List:_____

Has Your Child Ever Been Involved in a Car Accident? _____N_____Y , List:_____
Has Your Child Been Seen on an Emergency Basis? _____N_____Y , List:_____
Other Traumas Not Described Above? _____N_____Y , List:_____
Prior Surgery: _____N_____Y, List: _____
Menarche: _____N_____Y, Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age_____	Mumps	N / Y, Age_____
Rubella	N / Y, Age_____	Whooping Cough	N / Y, Age_____
Rubeola	N / Y, Age_____	Other	N / Y, Age_____

WE ARE HERE TO SERVE YOU, AND ENCOUAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctor to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____Policy #: _____

Signed: _____Witnessed: _____Date: ____/____/____