

# *Welcome To Pruitt*

## *Chiropractic*

**Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of chiropractic care available. We will be working together toward helping you reach your health and wellness goals.**

**If you ever have any questions about your chiropractic care, please do not hesitate to ask one of our highly educated and committed staff members. All of your questions, even the ones you never thought of asking, will be answered during your Report of Findings and Patient Workshops.**

**The following forms are necessary for us to serve you best. Just do your best to fill them out.**

**We look forward to a long, healthy relationship with you and your family.**

*Sincerely,*  
*Dr. Craig Pruitt*

## **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 so that we 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.

-Dorland's Medical Dictionary

**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 method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements. 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.

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(signature)

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(date)

**Service**

**Charges**

Consultation	No Charge
Initial Exam with Adjustment	\$85
Initial Exam without Adjustment	\$45
Re-Exam	\$45
Adjustment	\$40
Individual and Family Plans may be available	Based on individual recommendations

***Financial Policy***

We are committed to providing you the best chiropractic care possible and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time service is rendered unless other arrangements are made in advance. Other arrangements include our Individual and Family Plans. Details of these plans will be discussed with you when the doctor goes over your recommendations to get your spine and nerve system as healthy as possible. Payments can be scheduled monthly or by the visit.

\_\_\_\_\_ **Health Insurance:** If we are providers for your insurance plan and you have chiropractic benefits, we will file the insurance for you. If you have insurance that covers chiropractic and we are not a provider for that plan, we will give you all the information you need to get reimbursed quickly. This includes your diagnosis, prognosis and copies of your records or reports. We have found it easier for your record keeping and ours if we give you receipts at the end of your first visit and then once per month after that. Just send in your receipts with a copy of your claim form and your insurance company will communicate with you about your reimbursement.

If you are like most of our patients and choose to do an Individual or Family Plan, there is a possibility that we may file your insurance for you if we are not a provider for that insurance. We will discuss this option with you at your Report of Findings.

I have read and understand the above policy.

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**Patient Signature**

**Date**

# New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

## Patient Data

First Name  Last Name  Date  Email\*

\* Your email will NOT be shared with any 3d parties, and is used for occasional office announcements and promotions.

## Mailing address

Address  City  State  Zip

Telephone (Work)  (home)  Referred By

Age  Birth Date  Social Security #  Cell Phone #

Occupation  Employer

Marital Status  Spouse's Name  Spouse's Occupation

Spouse's Employer  Spouse's Health Status

Emergency Contact  Phone

## Current Complaints

Nature of Injury:  Automobile\*  Work  Other

Please describe:

Date of Injury  Date symptoms appeared

Have you ever had same condition?  No  Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractic care?  No  Yes

If yes, please describe

## Insurance Information

Name of party responsible for payment  Phone

Do you have health insurance?  No  Yes Name of company

**\* If an auto accident, please provide:**

Insurance Company Name  Contact Person

Phone:  Claim #

## Signatures

Name of the insured \_\_\_\_\_

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Have you been treated for any conditions in the last year?  No  Yes

If yes, please describe

Date of last physical exam  Is there a chance that you are pregnant?  No  Yes

Have you had X-rays taken?  No  Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

## Family History

**Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Have you ever suffered from:**

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

**A**=Ache                      **O**=Other  
**B**=Burning                  **P**=Pins & Needles  
**N**=Numbness                **S**=Stabbing

