

Patient Information and History

Date _____

1 PATIENT INFORMATION

Name: _____

Address: _____

Birthday: _____ Age: _____ Male Female

Social Security # _____ / _____ / _____

Occupation: _____

Employer: _____

Parents (if minor) _____

Single Married Divorced Widowed Separated

Spouse's Name: _____

Children _____

Who may we thank for referring you? _____

2 INSURANCE

Who is responsible? _____

Relationship to patient _____

Insurance ID number _____

Group / Claim number _____

Is patient covered by additional insurance? _____

Insurance Company _____

Subscriber # and name _____

Birth Date _____ Group# _____

3 ACCIDENT INFORMATION

Is your condition due to an accident? _____ Date: _____

Type of Accident? _____

Have you reported the Accident? _____

Insurance Workers Comp Employer

Additional Information _____

4 CONTACT INFORMATION

Home Phone _____ Cell _____

Work Phone _____

Email _____

Best way to reach you? Home Cell Work

Emergency _____

5 PATIENT CONDITION

What is your major complaint? _____

When did this condition begin? _____

Have you had the problem before? _____

Is this condition getting worse? _____ Does anything make it better? _____

How would you describe your condition? Burning Sharp Shooting Dull Aching Stiff Tingling

Throbbing Swelling Other _____

Does this condition interfere with your Work Sleep Daily Routine Recreation

Specific activities/movements that are painful _____

6

Health History

What other treatments have you had for this condition?

- Chiropractic Acupuncture Naturopathy Orthopedic Physical Therapy Medication Surgery

Are you under care for this condition (if yes who?) _____

Have you had previous Chiropractic Care? If yes explain _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ MRI _____
 Spinal Exam _____ CT _____

Name of medical doctor(s): _____

Would you like us to share progress reports with your other healthcare providers? Yes No

List Medication / Supplements _____

Check any of the following conditions you have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Arm / Shoulder Pain | <input type="checkbox"/> Headaches-Migranes | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Vertigo/Dizziness |

STRESSORS

- | | | |
|---|-------------|-------|
| <input type="checkbox"/> Smoking | Packs/Day | _____ |
| <input type="checkbox"/> Alcohol | Drinks/Week | _____ |
| <input type="checkbox"/> Coffee/Caffeine Drinks | Cups/Day | _____ |
| <input type="checkbox"/> High Stress Level | Reason | _____ |

EXERCISE

- None
 Moderate
 Daily
 Heavy

Have you had any:

	Description	Date
<input type="checkbox"/>	Automobile Accidents _____	_____
<input type="checkbox"/>	Surgeries _____	_____
<input type="checkbox"/>	Falls / Head Injury _____	_____
<input type="checkbox"/>	Broken Bones _____	_____

7

Authorization

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Tullius Chiropractic and Pilates Center to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

 Signature Date Parent (if patient is a minor)

Symptom Questionnaire

Name _____

Date _____

Age _____ Weight _____ Height _____ Sex _____

Instructions:

Mark those symptoms that apply to you.

Use a (1) if it is mild/ infrequent, a (2) if moderate and a (3) if severe/highly frequent.

- | | | |
|---|--|---|
| <input type="checkbox"/> A | <input type="checkbox"/> J | <input type="checkbox"/> T |
| <input type="checkbox"/> Finger aches | <input type="checkbox"/> Cholesterol/triglyceride problems | <input type="checkbox"/> Morning fatigue |
| <input type="checkbox"/> Knee problems | <input type="checkbox"/> K | <input type="checkbox"/> Severe stress |
| <input type="checkbox"/> Hip problems | <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Stress handling problems |
| <input type="checkbox"/> Tailbone problems | <input type="checkbox"/> L | <input type="checkbox"/> U |
| <input type="checkbox"/> B | <input type="checkbox"/> Eye/vision concerns | <input type="checkbox"/> Back/neck hurts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hearing/sensory integration | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Taste/smell problems | <input type="checkbox"/> Joints stiff |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> M | <input type="checkbox"/> Muscles hurt/stiff |
| <input type="checkbox"/> C | <input type="checkbox"/> Gum concerns | <input type="checkbox"/> Recent injury |
| <input type="checkbox"/> Arginase deficiency | <input type="checkbox"/> Taking statin/cholesterol drugs | <input type="checkbox"/> V |
| <input type="checkbox"/> Bladder concerns | <input type="checkbox"/> N | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Delayed healing/scarring | <input type="checkbox"/> Post-nasal drip, chronic infection |
| <input type="checkbox"/> Urinary tract issues | <input type="checkbox"/> Lowered disease resistance | <input type="checkbox"/> W |
| <input type="checkbox"/> D | <input type="checkbox"/> Rickets | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> B vitamin deficiencies | <input type="checkbox"/> Stubborn osteoporosis | <input type="checkbox"/> Menstrual difficulties |
| <input type="checkbox"/> E | <input type="checkbox"/> O | <input type="checkbox"/> Menopausal concerns |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Cocaine/Methamphetamine cravings | <input type="checkbox"/> GERD | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Focus problems | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Mood complaints | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> X |
| <input type="checkbox"/> Tobacco cravings | <input type="checkbox"/> Stomach bloats after eating | <input type="checkbox"/> Elevated liver enzymes |
| <input type="checkbox"/> F | <input type="checkbox"/> P | <input type="checkbox"/> Heavy metal detoxification |
| <input type="checkbox"/> Vitamin C deficiency | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Y |
| <input type="checkbox"/> G | <input type="checkbox"/> Constipation, stubborn | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> "Growing pains" | <input type="checkbox"/> Fatigue after fatty meals | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Gall bladder out | <input type="checkbox"/> Insomnia, but nervous |
| <input type="checkbox"/> Muscle cramps at night | <input type="checkbox"/> Greasy foods upset | <input type="checkbox"/> Muscles hurt or tight |
| <input type="checkbox"/> Nails weak | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stiff upon arising |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Q | <input type="checkbox"/> Z |
| <input type="checkbox"/> Poor calcium absorption | <input type="checkbox"/> Acid foods upset | <input type="checkbox"/> Afternoon fatigue |
| <input type="checkbox"/> Restless legs | <input type="checkbox"/> Eat few vegetables | <input type="checkbox"/> Appetite poor |
| <input type="checkbox"/> Seizures, myoclonic | <input type="checkbox"/> Overweight | <input type="checkbox"/> Attention problems |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Too acidic | <input type="checkbox"/> Chronically fatigued |
| <input type="checkbox"/> H | <input type="checkbox"/> R | <input type="checkbox"/> Circulation poor |
| <input type="checkbox"/> Calcium deficient | <input type="checkbox"/> Constant low level fatigue | <input type="checkbox"/> Cold extremities |
| <input type="checkbox"/> Diastolic pressure high | <input type="checkbox"/> Iron-deficient anemia | <input type="checkbox"/> Crave caffeine and/or coffee |
| <input type="checkbox"/> Insomnia, nonspecific | <input type="checkbox"/> Stools light | <input type="checkbox"/> Depression |
| <input type="checkbox"/> I | <input type="checkbox"/> S | <input type="checkbox"/> Dislike cold weather |
| <input type="checkbox"/> Aortic valve concerns | <input type="checkbox"/> Aging symptoms | <input type="checkbox"/> Dislike hot weather |
| <input type="checkbox"/> Exhaustion after exertion | <input type="checkbox"/> Alzheimer's in family | <input type="checkbox"/> Dislike vegetables/water |
| <input type="checkbox"/> General/severe exhaustion | <input type="checkbox"/> Black and blue spots | <input type="checkbox"/> Dizziness/vertigo |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Bug/spider bites | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Often feel cold/chilled | <input type="checkbox"/> Poison oak/ivy | <input type="checkbox"/> Fatigued in spurts |

PLEASE REMEMBER TO COMPLETE THE NEXT PAGE (OVER)

- Heart palpitations
- Hypertension or hypotension
- Lethargy
- Low libido, female
- Menses irregular
- Menstrual cramps
- Often skip breakfast
- Overweight
- Perspire easily
- PMS, headaches
- T-4 low (a thyroid hormone)
- Tobacco cravings
- Underweight
- AA
- Migraine headaches/aches
- Mild thyroid concerns
- On "Nature-Throid"
- Senior citizen
- BB
- Blood clots
- Thick blood
- Thrombosis
- CC
- Arthritic discomfort
- Autoimmune disorders
- Cardiovascular disease
- DD
- Diarrhea
- Food poisoning
- Meats upset
- Parasites
- Severely upset stomach
- EE
- Bowel gas after eating
- Indigestion, vegetarian
- FF
- Eczema
- Diarrhea
- GERD
- Itchy rashes
- Irritable bowel
- Multiple food allergies
- GG
- Libido, low (Male)
- Night urination (Male)
- Prostate swollen
- Urination difficult (Male)

- HH
- Chemo-toxicity
- Family history of Alzheimer's
- Severe reaction to flu shot
- II
- Angry/irritable
- Behavior problems
- Brain hurts
- Depression
- Learning math difficult
- Memory problems
- Mental fatigue
- Sibling violence
- JJ-A
- Exercise-induced asthma
- Stress/fatigue
- Tired in the morning
- JJ-B
- Nightmares
- JJ-C
- Low blood pressure
- JJ-L
- Enlarged liver
- JJ-LU
- Bronchitis
- Lung concerns
- JJ-M
- Breast problems
- Lactation difficulties
- JJ-O
- Infertility, male
- Low testosterone
- JJ-OV
- Female hair loss
- Infertility, female
- Insomnia, female recent
- JJ-P
- Celiac
- Gluten intolerance
- Grain indigestion
- JJ-S
- Lymphatic problems
- Narcolepsy
- Spleen out
- Toxicity complaints
- JJ-T
- Toddler infection

- JJ-TY
- Headaches before period
- PMS
- Severely low thyroid
- JJ-U
- Excessive menstrual flow
- Last month of pregnancy
- Postpartum depression
- Uterine concerns
- KK
- Fatigued since the flu
- Flu symptoms
- Immune system weak
- Recurring colds
- LL
- Ankles swollen
- Hypertension
- Kidney issues
- Urinary issues
- MM
- Benign peripheral neuroma
- Foot/feet hurt
- NN
- Vegetarian, low thyroid
- OO
- Frequent colds
- Indigestion, infective
- Viral concerns
- PP
- Alcohol craving, strong
- Diabetes
- Diet imperfect
- Flaky skin
- Hair loss
- Hypoglycemia
- QQ
- Anemia, pernicious
- Carpal tunnel/wrist hurts
- Dementia or homocysteine issues
- RR
- Capillary fragility
- Constipation, unusual
- SS
- Immune system low
- White spots on nails
- TT
- Allergies/Hay fever/Asthma

Please List Your Most Important Concerns and Other Items You Feel Are Important

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Tullius Chiropractic & Pilates Center

902 W. Grand Ave, Grover Beach, CA 93433
(805) 481-1566 Fax: (805) 481-5281
www.dr-t.net

Office Policy



TULLIUS CHIROPRACTIC
&
PILATES CENTER

Welcome to Our Office! Our goal is to serve you with exceptionally friendly and prompt service, and provide the best chiropractic care available. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

CLINIC HOURS & DAYS

Monday	9:00 a.m. – 6:00 p.m.
Wednesday	9:00 a.m. – 6:00 p.m.
Thursday	9:00 a.m. – 5:00 p.m.
Friday	9:00 a.m. – 6:00 p.m.

We close for lunch each day at 1:00 p.m. and return to the office at 3:00 p.m.

CONFIDENTIALITY

Initial _____

Our office complies with national standards to protect the privacy of your personal health information. We do not release your health information without your written consent. A copy of our policies can be obtained at the front desk.

APPOINTMENT SCHEDULING/MISSED APPOINTMENTS

Initial _____

Your doctor will designate a specific course of action to allow proper care, a must for spinal and postural correction. A personal appointment calendar will be designed for you to save time on each visit. **If an appointment must be changed, 24 hours' notice is appreciated. All missed appointments need to be made up later the same day or within 24 hours.** If you do not follow your schedule of care, you give up the right to expect results.

BROKEN APPOINTMENTS

Initial _____

"No show" appointments are subject to a \$20 charge. Please give 24 hours' notice so that we may service others in need at your time. Three "no show" appointments will result in your dismissal from care and all outstanding fees for services already rendered become immediately due and payable. Any pre-pay discount is lost when care is prematurely terminated and charges will be recalculated accordingly.

WELLNESS WORKSHOP

Initial _____

Every other Thursday at 5:15 p.m., Dr. Tullius provides an opportunity to enhance your understanding of health, wellness and chiropractic care, answers your questions, and will teach you how to stay healthy naturally. *All new patients are required to attend the Wellness Workshop within the first 2 weeks of starting care* as it shows a commitment on your part and will help you achieve the results you are seeking. There is no additional charge for attending a workshop and all friends and family are welcome.

CHILDREN/FAMILY

Initial _____

Once you understand that the nervous system controls and coordinates all functions of the body and that spinal conditions interfere with nerve flow, we expect that you would want everyone in your family to have their spines checked. We extend to all new patients the opportunity for you to have your family checked at our expense within 2 weeks of starting care.

FINANCIAL AGREEMENTS

Initial _____

It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you cannot keep or need to change your financial agreement, please inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

INSURANCE PARTICIPATION

Initial _____

We do not base your treatment program on your insurance participation and neither should you. Our goal is to correct your problem in the shortest amount of time and in the most cost-effective manner. *We have never turned anyone away because of his or her ability to pay, but we have turned people away for not making their health a priority!*

CHIROPRACTIC EXCELLENCE

Initial _____

The doctor is occasionally out of the office to attend advanced education seminars and conferences to further his professional excellence. We will build your schedule around these times.

REMEMBER

Initial _____

Spinal correction and healing take time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with your doctor. We want you to get the most from your chiropractic care.

REFERRALS

Initial _____

The success of our office and health of your loved ones depend greatly on your referrals. *The only way we can help the people you care about is to tell them about us.* If there is someone that you know that you would like to have invited to our office, please let us know.

I, the undersigned, have read the office policies and will honor them:

Patient's Signature

Date

Witness

Date



Name: (Print) _____ Date: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and for members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for chiropractic services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original).

**OUR OFFICE POLICY: *PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED
UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.***

For your convenience we accept CASH, CHECK, VISA, MASTERCARD, AND DISCOVER

Signature: _____ Date: _____

Signature: (Staff) _____ Date: _____

*Stephen Tullius, DC
902 West Grand Ave.
Grover Beach, CA 93433
(805)481-1566*