

OUR FINANCIAL POLICY

We are committed to the successful completion of your treatment program. Please understand the payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Full payment is expected at the time of service. We accept cash, checks, Visa, MasterCard, and American Express. We do not accept assignment of insurance, but do provide you with the necessary paperwork so that you may be re-imbursed by your insurance company.

We realize that due to the rising cost of healthcare, it makes it very difficult for the average person to receive often needed care. It is therefore our policy that no person will be turned away due to financial burdens. We have very flexible payment plans and we request that you agree to pay an amount that is affordable for you on a weekly basis.

REGARDING INSURANCE

Our policy is to recommend what is best for each patient. What an insurance company may or may not re-imburse is between the patient and the patient's insurance company. This office will not and cannot set its recommendations by what an insurance company's policy may be. This office will not enter into dispute with an insurance company regarding reimbursement. This is the patient's responsibility.

We do not know if your policy covers chiropractic care or not, and make no representations that yours does. Some insurance policies now cover chiropractic care and they range from a large deductible and a percentage of the bill to a no deductible and 100% of the bill.

SCHEDULING OF APPOINTMENTS

One of the most precious gifts is our time. To heal in a timely fashion it is important that you keep your appointments as scheduled by your doctor. Schedule ahead as this will assure you of getting the appointment time you want, and the care you need and deserve. Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

We are here to help you. Remember, neither one of us has anything to gain if you delay treatments for financial reasons. We will do everything possible to make your care affordable so that you can follow through on your treatment schedule.

I have read the financial policy. I understand and will abide to the terms of the agreement here within.

Name of Patient: _____ (Please print)

Signature of Patient: _____

Signature of Parent or Guardian: _____

Date: _____

ROSENTHAL CHIROPRACTIC
Natural Medicine Clinic
 3530 FOREST LANE SUITE 104 • DALLAS, TX 75234

PATIENT CASE HISTORY

Name: _____ Birth Date: _____ Age: _____ Today's Date: _____

Occupation: _____ Marital Status: Single Married Partner Divorced Widowed Separated

Home Address: _____ Number of children: _____

Home Phone#: _____ Work Phone#: _____ Cell Phone#: _____ Pager#: _____

Employer: _____ E-mail: _____

Social Security#: _____ Driver's License #/State: _____

Spouse's Name: _____ Spouse's Occupation: _____ Spouse's Age: _____

Spouse's Employer: _____ Spouse's Work#: _____ Cell Phone#: _____ Pager#: _____

Spouse's S.S.#: _____ Spouse's Driver's License #/State: _____

Referred by: _____ Relation: _____

Past Chiropractic Care: Yes No Who/When: _____

Please list the region(s) of complaint(s) and severity or severities of complaint(s) below. Please note the severity on a scale of 1 to 10 (1-Least; 10-Greatest): i.e. headaches, worse with movement

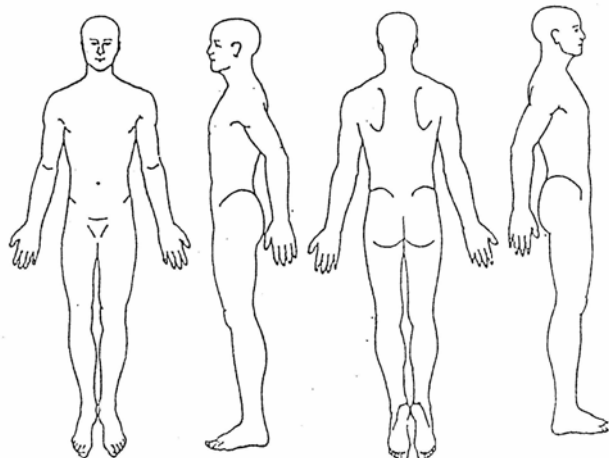
1 2 3 ④ 5 6 7 8 9 10

- 1. _____
1 2 3 4 5 6 7 8 9 10
- 2. _____
1 2 3 4 5 6 7 8 9 10
- 3. _____
1 2 3 4 5 6 7 8 9 10

- 4. _____
1 2 3 4 5 6 7 8 9 10
- 5. _____
1 2 3 4 5 6 7 8 9 10
- 6. _____
1 2 3 4 5 6 7 8 9 10

Use the following descriptive symbols. Draw the location of your complaint on the body outline below:

Aching or dull >>>>>	Burning X X X X X	Numbness 0 0 0 0 0	Tingling/Pins/Needles s +++++	Sharp/stabbing /////	Other =====
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Are you recovering from a cold or flu? _____ Are you pregnant? _____

List health problems that you are currently being treated for:

What types of therapy have you tried for this problem(s)?

- Acupuncture Conventional drugs Enemas Herbs Vitamins/minerals
 Chiropractic Diet modification Fasting Homeopathy Other _____

Are you presently taking any medications (prescription or over the counter)? No Yes Explain: _____

What is your current stress level? Please circle, 1 is lowest, 10 is highest: 1 2 3 4 5 6 7 8 9 10

What is the major cause of that stress? Family Finances Health Job Legal Relationship Other (please specify):

Do you consider yourself: Just right Overweight Underweight What is your weight:
Height: _____

Have you recently lost or gained 10 pounds or more over the last 3-4 months?

Do you wear: Corrective lenses Dentures Hearing aid Medical device, prosthetic, etc.

Are your present problems due to an injury? No Yes Auto On the job Personal injury Other _____

Have you made a report of your accident? No Yes Auto Employer Workers compensation Other _____

Are you now or have you been disabled (Service or work)? No Yes
When?: _____

Have you retained an attorney? No Yes (Name and Address): _____

List any accidents or falls and dates Car _____ Recreational vehicle _____

Sports _____ School _____ Other _____

List any broken bones(fractures) or dislocations: _____

Ever on crutches No Yes Explain: _____

Have you ever had any spinal taps or spinal infections? No Yes
Explain: _____

Were you ever knocked unconscious? No Yes Explain: _____

Have you ever had a lapse of memory? No Yes Explain: _____

Have you ever had x-rays taken? No Yes Explain: _____

Have you ever worked with toxic chemicals (dentistry, photo lab, gas station, etc.)? No Yes
Explain: _____

Any recent changes in your ability to: See Hear Taste Smell Feel hot/cold sensation Move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers, etc.)

Strong *like* for any of the following flavors: None Bitter Rich/fatty Salty Sour Spicy/pungent Sweet

Strong **DIS**like for any of the following flavors: None Bitter Rich/fatty Salty Sour Spicy/pungent Sweet

Do you prefer: Warmth (drinks, food, weather, etc.) Cold (drinks, food, weather, etc.) No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

<i>TIME(S) OF DAY YOU FEEL <u>THE BEST</u>:</i>	<i>TIME(S) OF DAY YOU FEEL <u>THE WORST</u>:</i>
--	---

- | | | | | | |
|--|---|---|--|---|---|
| <input type="checkbox"/> 7 a.m. – 9 a.m. | <input type="checkbox"/> 9 a.m. - 11 a.m. | <input type="checkbox"/> 11 a.m.– 1 p.m. | <input type="checkbox"/> 7 a.m. – 9 a.m. | <input type="checkbox"/> 9 a.m. - 11 a.m. | <input type="checkbox"/> 11 a.m.– 1 p.m. |
| <input type="checkbox"/> 1 p.m. – 3 p.m. | <input type="checkbox"/> 3 p.m. - 5 p.m. | <input type="checkbox"/> 5 p.m. – 7 p.m. | <input type="checkbox"/> 1 p.m. – 3 p.m. | <input type="checkbox"/> 3 p.m. - 5 p.m. | <input type="checkbox"/> 5 p.m. – 7 p.m. |
| <input type="checkbox"/> 7 p.m. – 9 p.m. | <input type="checkbox"/> 9 p.m. - 11 p.m. | <input type="checkbox"/> 11 p.m. – 1 a.m. | <input type="checkbox"/> 7 p.m. – 9 p.m. | <input type="checkbox"/> 9 p.m. - 11 p.m. | <input type="checkbox"/> 11 p.m. – 1 a.m. |
| <input type="checkbox"/> 1 a.m. – 3 a.m. | <input type="checkbox"/> 3 a.m. - 5 a.m. | <input type="checkbox"/> 5 a.m. – 7 a.m. | <input type="checkbox"/> 1 a.m. – 3 a.m. | <input type="checkbox"/> 3 a.m. - 5 a.m. | <input type="checkbox"/> 5 a.m. – 7 a.m. |

DO YOU EXPERIENCE ANY OF THESE GENERAL SYMPTOMS ON A DAILY BASIS?

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Depression | <input type="checkbox"/> Disinterest in sex | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Itching/rash | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chronic pain/inflammation | <input type="checkbox"/> Discharge | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Debilitating fatigue | <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |

OPERATIONS AND PROCEDURES

Date _____	Date _____	Date _____
_____ Vaccinations	_____ Tubes in ears	_____ Sinus
_____ Tonsillectomy	_____ Appendectomy	_____ Hernia
_____ Gall bladder	_____ Female organs	_____ Thyroid
_____ Back operation	_____ Rectal surgery	_____ Stomach
_____ Other	_____ Other	_____ Other

I have never had any surgeries (includes minor things such as mole removals).

What is your blood type (please mark): A+ A- B+ B- AB+ AB- O+ O-

How many bowel movements do you have per day (please mark): 1 2 3 every other day once a week other _____

Do you find yourself having any food cravings during the day or night? Yes No
If so, what foods?: _____

- What is your overall outlook on life? (mark all that apply):
- | | | | | | |
|---|--|--------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Positive | <input type="checkbox"/> Negative | <input type="checkbox"/> Happy | <input type="checkbox"/> Sad | <input type="checkbox"/> Depressed | <input type="checkbox"/> Excited |
| <input type="checkbox"/> Look forward to each day | <input type="checkbox"/> Difficult to face the day | <input type="checkbox"/> Angry | <input type="checkbox"/> Love my life | <input type="checkbox"/> Don't like my life | <input type="checkbox"/> Life is awesome |

MEDICAL HISTORY

- Alcoholism
- Allergies _____
- Anemia
- Arthritis
- Asthma
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Bruise easily
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Chest pain
- Chicken Pox
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Constipation
- Deafness
- Dental problems
- Depression
- Diabetes
- Diarrhea
- Diverticular disease
- Drug addiction
- Ear ache
- Eating disorder
- Eczema
- Epilepsy
- Emphysema
- Eye, ear, nose, throat probs.
- Environmental sensitivities
- Fatigue
- Fibromyalgia
- Food intolerance
- Foot trouble
- Gastro esophageal reflux dis.
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Hemorrhoids
- HIV/AIDS
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Itching
- Kidney or bladder disease
- Measles
- Mental illness
- Mental retardation
- Migraine headaches
- Mumps
- Neurological problems
- Night sweats
- Nose bleeds

- Osteoporosis
- Pneumonia
- Poor appetite
- Poor digestion
- Poor memory
- Seasonal affective disorder
- Sinus problems
- Skin problems
- Strokes
- Ulcer
- Urinary tract infection
- Varicose veins
- Venereal infection
- Whooping Cough
- Other _____

MEN ONLY

- Benign prostatic hypertrophy
- Decreased sex drive
- Infertility
- Prostate cancer
- STD
- Other _____

WOMEN ONLY

- Breast cancer
- Decreased sex drive
- Endometriosis
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Infertility
- Menstrual irregularities
- Pelvic inflammatory disease
- PMS
- STD
- Vaginal infections
- Other _____
- Age of first period _____
- Date of last gyn. exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____

- # of children _____
- # of pregnancies _____
- C-section _____
- Surgical menopause _____
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval between cycles _____ days
- Recent changes in flow _____

FAMILY HEALTH

- Arthritis, rheumatoid
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction

- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraines
- Obesity
- Osteoporosis
- Parkinson's
- Paralysis
- Stroke
- Suicide
- Thyroid trouble
- Other _____

HEALTH HABITS

- Cigarettes #/day _____
- Cigars #/day _____
- Wine #glass/day/wk _____
- Beer #glass/day/wk _____
- Liquor #glass/day/wk _____
- Coffee #cups/day _____
- Teas #cups/day _____
- Soda #/day _____
- Water #glass/oz/day _____

EXERCISE

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45min workouts
- 30-45 min workouts
- <30 min workouts
- Walk
- Jog, run, elliptical, etc.
- Weight lift
- Swimming
- Yoga
- Other _____

NUTRITION & DIET

- Animal/vegetable source
- Atkins diet
- Blood type diet
- Caloric restriction diet
- Carbo restriction
- Fat restriction
- Fit for life diet
- Jenny Craig diet
- Salt restriction
- See Food Diet (eat it all)
- Slim fast diet
- South Beach diet
- Vegan
- Vegetarian
- Zone diet
- Other _____

EATING HABITS

- 1 meal/day/ when _____
- 2 meals/day
- 3 meals/day
- Eat always even if not hungry
- Eat most calories late at night
- Eat on the run
- Eat plenty of veggies and grains
- Eat poorly as a rule
- Eat well as a rule
- Grazing meals
- No appetite
- Skip breakfast

SUPPLEMENTS

- Acidophilus
- Bach flowers
- Calcium
- CoQ10
- Enzymes
- Herbal remedies
- Homeopathics _____
- Magnesium
- Minerals
- Multivitamin
- Natural hormones
- Omega 3 oils (EPA/DHA)
- Protein shakes
- Vitamin B
- Vitamin C
- Vitamin E
- Zinc
- Others _____

YOUR HEALTH GOALS

- Be more motivated
- Be more muscular
- Be more organized
- Be stronger
- Be thinner
- Decrease your moodiness
- Get in the best shape of your life
- Get out of pain
- Get rid of your allergies
- Have more endurance
- Have more energy
- Have stronger nails and hair
- Improve the quality of your life
- Improve your bowel movements
- Improve your complexion
- Improve your memory
- Increase your sex drive
- Look 10 years younger
- Regain your youth
- Sleep better
- Stop being depressed
- Stop being indecisive
- Stop using medications (OTC)
- Think clearly

Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale (Please Circle)	0 – Never or almost never have the symptom 1 – Occasionally have it, effect is not severe 2 – Occasionally have it, affect is severe 3 – Frequently have it, effect is not severe 4 – Frequently have it, effect is severe
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	Point Score	Complaint		Point Score	Complaint
HEAD	0 1 2 3 4	Headaches	DIGESTION	0 1 2 3 4	Nausea, vomiting
	0 1 2 3 4	Faintness		0 1 2 3 4	Diarrhea
	0 1 2 3 4	Dizziness		0 1 2 3 4	Constipation
	0 1 2 3 4	Insomnia		0 1 2 3 4	Bloated feeling
EYES	0 1 2 3 4	Watery or itchy eyes		0 1 2 3 4	Belching/flatulence
	0 1 2 3 4	Swollen, reddened, or sticky eyelids		0 1 2 3 4	Heartburn
	0 1 2 3 4	Bags or dark circles under eyes		0 1 2 3 4	Intestinal/stomach pain
	0 1 2 3 4	Blurred or tunnel vision	JOINTS/MUSCLE	0 1 2 3 4	Pain or aches in joints
EARS	0 1 2 3 4	Itchy ears		0 1 2 3 4	Arthritis
	0 1 2 3 4	Earaches/infections		0 1 2 3 4	Stiffness or limitation of movement
	0 1 2 3 4	Drainage from ear		0 1 2 3 4	Pain or aches in muscles
	0 1 2 3 4	ringing/hearing loss		0 1 2 3 4	Feeling of weakness or tiredness
NOSE	0 1 2 3 4	Stuffy nose	WEIGHT	0 1 2 3 4	Bing eating/drinking
	0 1 2 3 4	Sinus problems		0 1 2 3 4	Craving certain foods
	0 1 2 3 4	Hay fever		0 1 2 3 4	Excessive weight
	0 1 2 3 4	Sneezing attacks		0 1 2 3 4	Compulsive eating
	0 1 2 3 4	Excessive mucous formation		0 1 2 3 4	Water retention
MOUTH/THROAT	0 1 2 3 4	Chronic coughing		0 1 2 3 4	Underweight
	0 1 2 3 4	Gagging, frequent need to clear throat	ENERGY/ACTIVITY	0 1 2 3 4	Fatigue
	0 1 2 3 4	Sore throat, hoarseness, loss of voice		0 1 2 3 4	Apathy, lethargy
	0 1 2 3 4	Swollen or discolored tongue, gums, lips		0 1 2 3 4	Hyperactivity
	0 1 2 3 4	Canker sores		0 1 2 3 4	Restlessness
SKIN	0 1 2 3 4	Acne	MIND	0 1 2 3 4	Poor memory
	0 1 2 3 4	Hives, rashes or dry skin		0 1 2 3 4	Confusion, poor comprehension
	0 1 2 3 4	Hair loss		0 1 2 3 4	Poor physical coordination
	0 1 2 3 4	Flushing, hot flashes		0 1 2 3 4	Difficulty in making decisions
	0 1 2 3 4	Excessive sweating		0 1 2 3 4	Stuttering or stammering
HEART	0 1 2 3 4	Irregular or skipped heartbeat		0 1 2 3 4	Slurred speech
	0 1 2 3 4	Rapid or pounding heartbeat		0 1 2 3 4	Learning disabilities
	0 1 2 3 4	Chest pain	EMOTIONS	0 1 2 3 4	Mood swings
LUNGS	0 1 2 3 4	Chest congestion		0 1 2 3 4	Anxiety, irritability, aggressiveness
	0 1 2 3 4	Asthma/bronchitis		0 1 2 3 4	Depression
	0 1 2 3 4	Shortness of breath	OTHER	0 1 2 3 4	Frequent illness
	0 1 2 3 4	Difficulty breathing		0 1 2 3 4	Frequent or urgent urination
				0 1 2 3 4	Genital itch or discharge

Score totals

Score totals

Adapted from Metagenics and ImmunoLaboratories, Inc. 1997.

Do you suffer from any condition other than that for which you are now consulting us? No Yes Explain:

I clearly understand and agree that all services rendered to me will be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize Dr. David Rosenthal to examine and treat my condition as he/she deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be performed. Dr. Rosenthal will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis.

Patient/Guardian's Signature: _____ Date: _____
Patient/Guardian's Name: _____ (Please Print)