

Welcome

I would like to take this opportunity to welcome you to my office. My goal is to help you gain better health in the least amount of time and expense to you. To help my office run as efficiently as possible, I would like to review my office policies to avoid possible future misunderstandings.

All patients are expected to pay in full at the time of service, as I am not contracted by any insurance company. It will be the patient's responsibility to contact their provider to determine if they have **OUT OF NETWORK** chiropractic coverage. As a courtesy to those who have **OUT OF NETWORK** chiropractic coverage, your submissions will be sent electronically. If there are any issues, you will be the primary contact with the insurance company.

Payments may be made via cash, check, or major credit cards (excluding American Express).

I make it a daily goal to stay on schedule, however, emergencies do occur. I appreciate your promptness with scheduled appointments. **We ask that a 24 hour notice be given if you cannot keep your scheduled appointment so that we may serve others in need. A fee will be charged to all cancels, transfers, and no shows without a 24 hour notice.**

I appreciate the opportunity you are giving us to participate in your journey to better health and wellness. "Your Health is our main concern!!!"

Anytime you need assistance, please feel free to talk to Cindy and CiCi.

Yours in Health,

Dr. Christopher Thoma and Staff

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE

Signature: _____ DATE: _____



TOTAL HEALTH CORRECTION

— WELLNESS AND CHIROPRACTIC —

510 Baxter Rd. Suite #8
 Chesterfield, MO 63017
 (636) 207-6600
 Totalhealthcorrection.com

Patient Assessment Questionnaire

Name: _____ Date: _____

Address: _____ City/State: _____ Zip: _____

SSN: _____ - _____ - _____ Birth date: _____ Age: _____ M S W D

Phone 1: _____ Phone 2: _____ E-mail: _____

Is it okay to leave a voice message? (Circle one or all) Home Cell Work None

May we send you e-mail newsletters? Yes No

How should we send you appointment reminders? Text: _____ E-mail

Occupation: _____ Employer: _____

Referred By: Friend Relative Advertisement Other _____

Which one of our patients should we thank for referring you? _____

Please list your health concerns in order of importance that you wish to address:

Concern	Date of Onset	What makes it better?	What makes it worse?	Severity (1 -10)

Other doctors seen for your complaint (s):

Chiropractic Care (D.C.) Were you satisfied? Yes No Name: _____

Medical Care (M.D.) Were you satisfied? Yes No Name: _____

Other Care Were you satisfied? Yes No Name: _____

Office Policies: *I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, that Total Health Correction Chiropractic will prepare the necessary reports and claims to assist me in reimbursement from the insurance company and that any amount authorized to be paid directly to Total Health Correction Chiropractic 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 I am personally responsible for payment. I also understand that no cures are promised and any risks regarding care will be explained to me. I now authorize Ballwin Chiropractic Center to proceed with necessary care and treatment.*

Patient Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Patient Name: _____

Medication	Dose	Condition taken for	Time of day taken

List all prescriptions, over-the-counter medications and herbal, homeopathic, hormonal, and nutritional (vitamins/minerals) supplements, you are **currently taking**:
Use back of page if more space is needed.

Have you ever taken any of the following medications?:

- Birth Control Antibiotic Antidepressant Hormones Antifungal
Weight Loss Blood Pressure Cholesterol Lowering Anticoagulants

Please list all allergies and sensitivities (food, environmental, and seasonal):

Lifestyle

Alcohol: Never ___ Currently ___ Once/Wk ___ 2-4 Times/Wk ___ 3-5 Times/Wk ___ More ___

Tobacco: Cigarettes ___ Chewing Tobacco ___ Cigar ___ Pipe ___
Never ___ Currently ___ Per Day ___ Previously ___ How Long Ago ___ Per Day ___

Dine Out: Never ___ Currently ___ Once/Wk ___ 2-4 Times/Wk ___ 3-5 Times/Wk ___ More ___

Exercise: Never ___ Currently ___ Once/Wk ___ 2-4 Times/Wk ___ 3-5 Times/Wk ___ More ___

Changed jobs: Within Last 2 Months ___ Last 6 Months ___ Last 12 Months ___

Divorced: Within Last 6 Months ___ Last 12 Months ___ Last 2 Years ___

Work over 60 hours/week: Always ___ Usually ___ Occasionally ___ Never ___

Diet

Read the following questions and fill in the number that applies:

Key: 0 = Do not consume/use 1 = Daily 2 = 2-3 times/month 3 = Weekly

- ___ Artificial sweeteners ___ Diet Often ___ Milk Products ___ Water, distilled
___ Candy or other sweets ___ Fried Foods ___ Non-herbal tea ___ Water, tap
___ Carbonated beverages ___ Luncheon Meats/Hot Dogs ___ Water, well
___ Coffee ___ Margarine ___ Refined sugar ___ Refined flour/baked goods

**** Female Patients **** Are you pregnant at this time? Yes No Due Date: _____

Hysterectomy: Full Partial Year: _____ Menopausal: Yes No Perimenopausal: Yes No

Family History

√ Mark the following conditions as they pertain to your immediate family.

	Mother	Father	Brother	Sister	Children
Diabetes					
Hypertension					
Heart Problems					
Kidney Problems					
Cancer					
Obesity					
Scoliosis					
Back Problems					
Osteoporosis					
Headaches					
Birth Defects					
Thyroid					
Smoker					
Anemia					

Surgical History

Please list all medical procedures and surgeries:

Surgery/Procedure	Date	Reason for procedure

Past Medical History

Which of the following conditions have you been diagnosed present or past?

√ Mark the following conditions

- Abscesses Tonsillitis Goiter Lactose Intolerant Malaria
- Diabetes Peritonitis Measles Epilepsy/Seizures Skin Disease
- Heart Disease Pleurisy Kidney Disease Warts Stroke
- Mumps Chicken Pox Worms/Parasites Prostatitis Gallstones
- Asthma Eating Disorder Tuberculosis Leukemia Hepatitis
- Pelvic Inflammatory Rheumatic Fever Mononucleosis Typhoid Fever Pneumonia
- Cold Sores HIV Appendicitis Venereal Disease Psychiatric Disorder
- High Blood Pressure Cancer (type): _____

List any other conditions the doctor should be aware of:

System Review

√ Mark the following conditions you are **currently** experiencing (past 30 days).

General

- | | | | | |
|---|----------------------------------|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> allergies | <input type="checkbox"/> chills | <input type="checkbox"/> convulsions | <input type="checkbox"/> depression | <input type="checkbox"/> bruise easily |
| <input type="checkbox"/> loss of weight | <input type="checkbox"/> fatigue | <input type="checkbox"/> fever | <input type="checkbox"/> hives | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> itching | <input type="checkbox"/> night sweats | <input type="checkbox"/> wheezing | <input type="checkbox"/> nervousness |

Gastrointestinal

- | | | | | |
|--|-----------------------------------|--|--|---|
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> vomiting blood | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> jaundice |
| <input type="checkbox"/> liver problems | <input type="checkbox"/> nausea | <input type="checkbox"/> stomach pain | <input type="checkbox"/> poor appetite | <input type="checkbox"/> poor digestion |
| <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> vomiting | <input type="checkbox"/> gall bladder problems | | |

Eye/Ear/Nose/Throat

- | | | | | |
|--|--|---|--------------------------------------|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> double vision | <input type="checkbox"/> deafness | <input type="checkbox"/> earache | <input type="checkbox"/> ear discharge |
| <input type="checkbox"/> ear noises | <input type="checkbox"/> enlarged thyroid | <input type="checkbox"/> frequent colds | <input type="checkbox"/> hay fever | <input type="checkbox"/> loss of smell |
| <input type="checkbox"/> nasal obstruction | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> pain in eyes | <input type="checkbox"/> poor vision | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> tonsillitis | <input type="checkbox"/> difficulty swallowing | | | |

Respiratory

- | | | | | |
|-------------------------------------|--|---|--|---|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> chronic cough | <input type="checkbox"/> spitting blood | <input type="checkbox"/> spitting phlegm | <input type="checkbox"/> difficulty breathing |
|-------------------------------------|--|---|--|---|

Muscles/Joints/Bones

- | | | | | |
|------------------------------------|---|--|-----------------------------------|---|
| <input type="checkbox"/> backache | <input type="checkbox"/> foot problems | <input type="checkbox"/> shoulder pain | <input type="checkbox"/> hip pain | <input type="checkbox"/> painful tailbone |
| <input type="checkbox"/> deformity | <input type="checkbox"/> swollen joints | <input type="checkbox"/> knee pain | <input type="checkbox"/> limping | <input type="checkbox"/> weakness |

Cardiovascular

- | | | | | |
|---|--------------------------------------|---|--|--|
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> chest pain | <input type="checkbox"/> coughing blood | <input type="checkbox"/> weakness | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> rapid heart | <input type="checkbox"/> slow heart | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> low blood pressure |

Genitourinary

- | | | |
|---|--|--|
| <input type="checkbox"/> burning on urination | <input type="checkbox"/> painful urination | <input type="checkbox"/> recurrent bladder infection |
| <input type="checkbox"/> increased urination at night | <input type="checkbox"/> blood in urine | <input type="checkbox"/> difficulty starting |
| <input type="checkbox"/> increased urination at day | <input type="checkbox"/> kidney stones | |

Have you had laboratory testing completed in the past 12 months? Yes No

Will you provide a copy to Total Health Correction? Yes No

** Weight Loss Patients**

What diets have you tried? What was the outcome?

Do you feel like you eat healthy? Yes No

Do you feel like you should be losing weight but are not? Yes No

What is your stress level? 1 = All is Well, 10 = Immediate Help Needed _____

Name: _____

Detoxification and Drainage Questionnaire

Point Count	Points
Never or almost never have the symptom	0
Occasionally have it	1
Occasionally have it, effect is severe	2
Frequently have it, effect is not severe	3
Frequently have it, effect is severe	4
Emotions	Points
Irritability	
Nervousness	
Mood swings	
Frequent crying	
Aggressive behavior, i.e., road rage	
Anxiety	
Fear	
Confusion	
*Depression	
*Suicidal thoughts	
Total Emotions	
Skin	Points
Increased sweating, ear wax, oily skin	
Skin rashes	
Brown spots on hands and face	
Boils	
Skin tags (small hanging warts)	
Acne	
Eczema	
Fever blisters	
Warts	
Total Skin	
Ear, Nose and Throat	Points
Increased salivation	
Mouth ulcers	
Common cold	
Sinusitis	
Sore throat	
*Ear infections	
Hay fever	
Loss of smell	
Cough	
Total Ear, Nose and Throat	
Mind and Brain	Points
Hyperactivity	
Stammering when speaking or problem finding words	
Difficulty in concentration	
Sleep disturbance	
Difficulty in making decisions	
Headache	
Poor memory	

*These symptoms are indications of conditions that should not be treated with the Heel Detoxification and Drainage protocols alone.

Name: _____

Detoxification and Drainage Questionnaire

Poor coordination	
*Compulsive behavior	
*Sleep disturbance	
Memory loss	
Total Mind and Brain	
Digestive System	Points
Loose stools	
Diarrhea	
Heartburn	
Constipation	
Bloating	
Abdominal pain	
Intolerance to certain foods	
Nausea or vomiting	
Severe diarrhea with blood or mucous	
Total Digestive System	
Kidney	Points
Increase in urination frequency and amount	
Needing to get up in the night to pass urine	
*Urinary tract infections and cystitis	
*Kidney stones	
*Blood in the urine	
Total Kidney	
Joints and Muscles	Points
Fleeting muscle aches or joint aches	
Tendinitis (e.g., tennis elbow, golfer's elbow, achilles tendinitis)	
Gout	
Arthritis	
Fibromyalgia	
Total Joints and Muscles	
Metabolism	Points
Feeling of coldness	
Hypoglycemia	
Craving certain foods	
Water retention	
Obesity	
Cellulite	
Total Metabolism	
GRAND TOTAL	

*These symptoms are indications of conditions that should not be treated with the Heel Detoxification and Drainage protocols alone.



TOTAL HEALTH CORRECTION
 ——— WELLNESS AND CHIROPRACTIC ———

Dr. Christopher Thoma
 510 Baxter Rd. Suite #8
 Chesterfield, MO 63017
 (636) 207-6600
 Totalhealthcorrection.com

DISCLOSURE AND CONSENT TO CHIROPRACTIC SERVICES

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various diagnostic tests, acupuncture or other related remedies on me (or the patient named below, for whom I am legally responsible) by Dr. Chris Thoma, the Doctor of Chiropractic, and/or those working at the office who now or in the future treat me while employed by, working for or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, or other clinic personnel, my diagnosis, the nature and purpose of chiropractic adjustments and the plan of treatment or other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks and hazards to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or not improvement of symptoms or pain. I understand that neither the practice of chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the Doctor at the time; and that 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 on the facts then know, is in my best interests. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above Consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this Consent Form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

 To be completed by the patient:

 To be completed by doctor or staff:

 Print Name

 Witness to patient's signature

 Signature of Patient or Legal Guardian

 Date Signed

 Date Signed

DOCTOR'S NOTES: