

Welcome to the Office of Dillberg Integrated Healthcare

2711 Ala Kinoiki - Koloa Hawaii, 96766
(808) 742-9326

In this office we employ Chiropractic, Traditional Chinese Medicine, Pettibon Spinal Technologies, Egoscue Postural Assessment, Acupuncture, Nutritional Therapies, Personalized Detoxification programs, and along with advanced testing and diagnostic techniques. Our goal is to provide comprehensive holistic healthcare that focuses on optimal function and vitality.

Listed below are 6 basic categories of care. Please place a number next to each type of care – to show your current healthcare priorities. This way we will be able to develop a healthcare program for you that will address the issues you care most about.

#___ **Acute Care** – Treatment focusing on pain or symptoms. Scheduled on a visit by visit basis until symptoms subside. This type of care does not address underlying causes, or prevention. *Usually a high priority for severe and acute pain.*

#___ **Spinal Correction/Rehabilitative Care** – Advanced techniques (Pettibon Spinal Technologies & Egoscue) are used to strengthen the muscles and ligaments that hold the spine in proper alignment. A personalized program is designed for each patient, which addresses specific misalignments and weaknesses. X-ray evaluation documents progress. *This type of care is important for those with reoccurring pain who want lasting correction.*

#___ **Nutritional Balancing & Detoxification** – Specific testing (High Resolution Blood Analysis, Bio Terrain Lab Tests, Blood, Saliva or Urine panels) to determine chemical imbalances or nutritional weaknesses that can cause degenerative disorders. A personalized health plan with diet and nutritional supplementation can be designed for you.

#___ **Neuro Emotional Balancing** – Specialized techniques (Bio Energetic Synchronization Technique, Neuro Emotional Technique, and Traditional Acupuncture Techniques) are employed to reduce stress, and decrease mental and emotional triggers that interfere with good health. These techniques are taught to the patient so that he or she can use them at home to maintain balance.

#___ **Maintenance & Healthy Living** - When a patient is symptom free we can work together to develop a program for ongoing good health incorporating structural balance, nutrition, stress reduction, and lifestyle.

#___ **Strength Training & Support** - Get into shape or advance to peak performance. Assess nutritional needs and align your body's mental and physical abilities for strength and vitality. Functional Exercise maximizes muscle and metabolism while reducing recovery and preventing injury.

Authorization of Care

I authorize and agree to allow Dillberg Integrated Healthcare to care for my health incorporating spinal adjustments, acupuncture, rehabilitative exercises, nutrition, and/or Neuro Emotional techniques to restore normal biomechanical, neurological, and biochemical function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I understand that Dr. Dillberg is not a Medicare Provider.

This office will not be held responsible for any health conditions or diagnosis which are pre-existent, given by another healthcare practitioner, or are not related to the conditions diagnosed or treated by this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations for my care, I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees will be payable at that time.

Patient's Signature

Date

Parent or Guardian

WHO SHOULD RECEIVE CHARGES ON YOUR ACCOUNT?

___ Patient Payment ___ Parent/Spouse ___ Worker's Comp. ___ Auto Insurance

___ Please provide forms for Insurance Reimbursement.

New Patient
Confidential Information

Name _____ Age _____ today's date _____

Address _____

City _____ State _____ zip _____

Home Phone _____ cell _____ email _____

Work Phone _____ occupation _____

Employer _____ work address _____

Birthdate _____ Social security _____

Marital Status _____ # of Children _____

Names and Ages of Children _____

Spouse's name _____ employer _____

Purpose of this visit

Who referred you to our office? _____

Reason for this visit _____

Is this related to an auto accident or work injury? _____

Please describe _____

What aggravates your symptoms? _____

Has anything relieved your symptoms? _____

Have you experienced this condition before? When? _____

Have you seen any other doctors for this condition? Who? _____

What was the treatment and how did you respond? _____

Healthcare Experience

Have you seen a Chiropractor before? When? _____

Have you seen a Doctor of Chinese Medicine/Acupuncturist before? When?

Have you seen a Nutritionist before? When? _____

How did you respond? _____

Did you know that your posture determines your health? _____

Are you aware of any poor postural habits for yourself? _____

Are you aware of any poor postural habits for your spouse/or children? _____

The most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever been told you carry your head forward? _____

Health History

How long has it been since you felt really great?

Drug/Medication History. How many times have you been on antibiotics?

The most recent time/what for: _____

How many times in your life have you been on Steroids ? (inhalers, injections, pain killers, etc.)

The most recent time/ what for: _____

List medications taken for Pain: _____

For High Blood Pressure/Cholesterol: _____

List any other medications and approximate dates of use: _____

History of Trauma/Accidents/Surgeries. Please list all major falls, broken bones, auto accidents or surgeries:

Childhood: _____

Young Adult: _____

More Recent: _____

Stress Chart Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being lowest)

1 2 3 4 5 6 7 8 9 10

Identify major causes of stress:

List the time of day you feel the most energy or the least symptoms

List the time of day you feel your worst or most symptoms

Please list your health concerns by Priority:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Health Lifestyle

Do you exercise? Yes No How Often? _____

What activities? _____

Do you smoke? Yes No How Much? _____

Do you drink alcohol? Yes No How Much? _____

Do you drink coffee? Yes No How Much? _____

Do you take any supplements (i.e.:vitamins, minerals, herbs)? _____

Health Conditions

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called **Subluxations**. It has been extensively documented that subluxations, causing stress to your nerves will weaken and distort the overall structure of your spine. This results in a weakened and distorted **POSTURE**. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called **Forward Head Syndrome** (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health conditions that you may be experiencing as a result of misalignments to your spine.

CERVICAL SPINE (NECK)

Do you experience ...?

- | | | |
|--------------------------------------------------------------|-------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling into arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent Colds/flu |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands/feet | |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid Conditions | |
- Explain: _____

THORACIC SPINE (UPPER BACK)

Do you experience... ?

- | | |
|-----------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Recurrent lung infections/bronchitis |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain on deep inspiration/expiration |

THORACIC SPINE (MID BACK)

Do you experience ...?

- | | |
|----------------------------------------------------|--------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Tired/irritable after eating or when you haven't eaten for awhile |

LUMBAR SPINE (LOWER BACK)

Do you experience ...?

- | | | |
|----------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Numbness/tingling into your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Constipation/Diarrhea | |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (females) | |
| <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Sexual Dysfunction | |

Please list any health conditions not mentioned:
