



Joseph M. Serpe, D.C.

## NEW PRACTICE MEMBER APPLICATION

Dear Prospective Practice Member,

Welcome to The NeuroPlus Institute!

We specialize in helping patients to achieve their highest level of health through our Structural, Neurologic and Metabolic corrective care programs.

This application is extensive because we are committed to being thorough with your care. The questions we ask provide important information that will help us determine if we can help you. You deserve the best, so please give us yours when you answer these questions.

Please remember to sign the last page indicating you have thoroughly completed this application and return this application and any lab and diagnostic test results you have received (in the last 6-12 months) at least one business day before your scheduled appointment. This must be accomplished before your consultation. Please feel free call us at 630-357-2299 if you need assistance.

Thank you. We look forward to serving you.

Sincerely,

A handwritten signature in black ink that reads "Joseph M. Serpe, D.C." in a cursive style.

Joseph M. Serpe, D.C.



## Patient Condition

What activities or positions relieve your condition:

- Heat       Lying down       Sitting       Sitting       Stretching       Other  
 Ice       Medication       Massage       Standing       Exercise

Have you ever had this condition before?  Yes  No If yes, when? \_\_\_\_\_

Were you treated for this condition or a similar one before?  Yes  No If yes, when/by whom? \_\_\_\_\_

## Health History

Do you have any allergies? (food, contact, environmental) \_\_\_\_\_

List any vitamins, herbs and supplements \_\_\_\_\_

When was your last: Physical examination \_\_\_\_\_ Blood/lab work \_\_\_\_\_ X-ray study \_\_\_\_\_

Injuries/Surgeries you've had and when? \_\_\_\_\_

Have you had or do you have any of the following conditions or diseases? ***Please check any that apply to indicate yes***

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AD/HD                      | <input type="checkbox"/> Connective tissue issues  | <input type="checkbox"/> HIV/AIDS             |
| <input type="checkbox"/> Adrenal disorder           | <input type="checkbox"/> COPD                      | <input type="checkbox"/> Kidney disease       |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Depression                | <input type="checkbox"/> Knee surgery         |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Liver disease        |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Digestive/bowel problems  | <input type="checkbox"/> Marfan's syndrome    |
| <input type="checkbox"/> Autoimmune disorder: _____ | <input type="checkbox"/> Dizziness or vertigo      | <input type="checkbox"/> Multiple sclerosis   |
| <input type="checkbox"/> Bleeding disorder          | <input type="checkbox"/> Ear infections            | <input type="checkbox"/> Osteoporosis/penia   |
| <input type="checkbox"/> Blurred vision             | <input type="checkbox"/> Fibromyalgia              | <input type="checkbox"/> Parkinson's disease  |
| <input type="checkbox"/> Bowel/Bladder problems     | <input type="checkbox"/> Food sensitivity          | <input type="checkbox"/> Rotator cuff problem |
| <input type="checkbox"/> Buzzing in ear             | <input type="checkbox"/> Fusions (spinal, joint)   | <input type="checkbox"/> STI/STD              |
| <input type="checkbox"/> Cancer - type? _____       | <input type="checkbox"/> Gout                      | <input type="checkbox"/> Shoulder surgery     |
| <input type="checkbox"/> Carpal tunnel syndrome     | <input type="checkbox"/> Gall Bladder issue        | <input type="checkbox"/> Spinal surgery       |
| <input type="checkbox"/> Celiac disease (gluten)    | <input type="checkbox"/> Immune compromise         | <input type="checkbox"/> Stroke/TIA           |
| <input type="checkbox"/> Chest pains                | <input type="checkbox"/> Heart disease             | <input type="checkbox"/> Thyroid problems     |
| <input type="checkbox"/> Chronic fatigue            | <input type="checkbox"/> Hepatitis (A, B, C, etc.) | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Cold hands or feet         | <input type="checkbox"/> Herpes                    | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Colitis/diverticulitis     | <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Compression fractures      | <input type="checkbox"/> Hip replacement           |   |

Are there any conditions that run in your family?  Yes  No If yes, what condition(s) and which family member? \_\_\_\_\_

## Personal and Social Health History

Are you currently pregnant, or do you think you may be pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

How many hours per week do you typically work/attend school?  <20 hrs  20 hrs  30 hrs  40 hrs  40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc.)? \_\_\_\_\_

Do you exercise?  Yes  No If yes, how often and what type? \_\_\_\_\_

How would you rate your eating habits?  Excellent  Pretty good  Could be better  Needs improvement

How well do you sleep?  Excellent  Pretty good  Restless  Can't sleep  Wake up often

How many hours of sleep do you get daily? \_\_\_\_\_ hours ***and*** Do you feel rested in the morning?  Yes  No

How is your energy overall?  Full power  OK  Low  Sporadic/Generally fatigued  I depend on caffeine for energy

How often do you get 'sick'?  almost never  I tend to catch what is going around  I'm constantly sick

What do you hope to receive from our program? \_\_\_\_\_

Thank you for completing our health care questionnaire

## My Current Diet

Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

List your diet on an average day below. Don't worry about trying to impress us by telling the doctor what you think he wants to hear. Just think about how you eat on an average day.

Check all the meals that you eat each day (check all that apply):

Breakfast     Snack     Lunch     Snack     Dinner     Snack

A typical breakfast consists of \_\_\_\_\_

A typical lunch consists of \_\_\_\_\_

A typical dinner consists of \_\_\_\_\_

A typical snack between meals consists of \_\_\_\_\_

How much water do you drink/day?

Do you drink green/black tea?

Do you drink herbal tea? YES / NO What is it the tea? \_\_\_\_\_

How much coffee do you drink /day?

How much soda pop do you drink/day?

List any known food sensitivities or allergies: \_\_\_\_\_

List the foods that you crave: \_\_\_\_\_

## My Surgical History

List the type of surgery, reason for the surgery and year performed. (ie: left breast surgery for cancer in 2004)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

## Medications

Name \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

List the name of each current prescribed and over the counter medications, its prescribed use and any side-effects/reactions/positive responses. (example of use: BCP - birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.). (example of side-effect could be Tylenol caused liver enzymes to increase).

	Medication	The name of the condition or purpose for taking this medication  (i.e. - birth control pills for acne or endometriosis)  (We don't need the number of pills or the dosage - mg/day info)	Any Side-effects
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

# Chronic Condition Narrative History

The purpose of the following questions are to help us understand everything you've been through concerning your chronic condition. On a separate piece of paper; please write (or type) as much as you would like to give us the information needed to help you (use as many pages as it takes). This process brings you clarity and makes sure that nothing is missed.

We want to be the last office that you'll ever need to clear up this problem.

1. Write/Type out your complete narrative health history (be sure to include rough dates, tests performed, treatments that worked and how well, how long did they help, what treatment didn't help)?
2. Was there a pivotal illness/injury/stressor when your condition first developed? (ie - you had Lyme's or Mononucleosis?)
3. What diagnoses have other doctors given you for your current condition(s)?
4. Why do you think other doctors/therapies have failed you?
5. Why do you think I can help you?
6. In your heart of hearts what do you hope to gain by coming to see us? How long do you think it will take to accomplish this?
7. Does your family support you coming to our office?
8. What you think is wrong?

Return to:

Joseph M. Serpe, D.C.  
651 Amersale Drive, Suite 109  
Naperville, IL 60563  
630.357.2299  
630.357.0204 (fax)

## **LIFE IMPACT ASSESSMENT**

As you answer the following questions, please do not minimize any impact of your health challenge on you and your family's life no matter how small it appears. We consider any loss of ability or function which affects your daily life as significant. **Please check as many that apply; add additional comments in the margin or on the back as needed.**

1. **How have others been affected by your health condition?**  No one is affected   
Haven't noticed any problem  They tell me to do something  People avoid me  
 Other: \_\_\_\_\_
2. **What are you afraid this might be (or is beginning) to affect (or will affect) in any way?**  
 Energy  Your mood / attitude  Stress  Job  Self Esteem  Future ability   
Marriage  Any relationships (frequency visiting, quality, etc.)  Sleep  Time  Finances  
 Freedom  Other: \_\_\_\_\_
3. **Are there health conditions you are afraid this might turn into?**  Family health  
problems  Allergies  Asthma  Depression  Anxiety  More Serious Neurological  
Disorder  Other: \_\_\_\_\_
4. **How has your health condition affected your job, relationships, finances, family, or  
other activities?** Please give examples: \_\_\_\_\_
5. **What has that cost you?** (time, money, happiness, freedom, sleep, promotion, etc.)  
Try to give 3 examples: \_\_\_\_\_
6. **What are you most concerned with regarding your problem?** \_\_\_\_\_  
\_\_\_\_\_
7. **Where do you picture being in the next 1-3 years if this problem is not taken care of?**  
\_\_\_\_\_  
\_\_\_\_\_
8. **What would be different/better without this problem? Please be specific:**  
\_\_\_\_\_  
\_\_\_\_\_
9. **What do you desire most to get from working with us?**  
\_\_\_\_\_  
\_\_\_\_\_
10. **What is that worth to you?**  
\_\_\_\_\_  
\_\_\_\_\_

## **SELF ASSESSMENT & TREATMENT GOALS**

Even though you are not a specialist, what, in your opinion, do you think the real problem is?

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Would you consider this problem (check one):  MINIMAL (Annoying but causing NO limitations)  
 SLIGHT (Tolerable but causing a little limitation)  MODERATE (Sometimes tolerable but causing limitations)  
 SEVERE (Causing significant limitations and/or concern)  EXTREME (Near constant (Limits me > 80% of the time)

### **Which best describes your health goals:**

- Symptom Relief Only (not interested in correction of the problem).
- Would like to find the cause of this problem and have it improved or corrected:  
**How strong is your desire to correct this problem**  Mild  Moderate  High  
 Extremely High
- Wellness / Preventative care – I just to stay well and be at optimal health

How supportive is your Spouse/Family/Significant Other to you seeking care? (Be very specific)

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Are you able to handle a complete investigation and management of your case? \_\_\_\_\_

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What is YOUR idea of an ideal doctor? \_\_\_\_\_

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- ▶ There may be services that your insurance company does not cover. If this is the case, we have many reasonable and affordable payment options. If you have a problem that we can help, would you be willing to pay out of pocket to get better?  Yes  No
- ▶ After considering your consultation, history and exam findings, you may need additional tests that require payment at time of service. If this is required, you will be informed in advance.
- ▶ Method of payment for any additional uncovered services today:  
 Cash  Check  Credit Card

I, \_\_\_\_\_ (Please Print Full Name of Parent/Guardian), have thoroughly completed this application and all supportive documents, answering every question to the best of my ability. Additionally, I have read and reviewed all supportive information that has been included with my application – this may include written or recorded material. If I do not have the means to review the material, I have contacted The NeuroPlus Institute (Joseph Serpe, D.C.) to arrange for additional support. I understand that failure to complete this application fully and review the enclosed material may mean the doctor will not be able to conduct the consultation and evaluation of your child. I will also bring any recent labs, images or reports. I give this office permission to communicate with me by way of mail, telephone and email.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_