

Dillberg Integrated Healthcare  
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## Welcome to a New Paradigm in Health Care

### ***All New Patient Information is Confidential***

The purpose of our clinic is to support each individual in understanding their health potential and to achieve their healthcare goals. All patient education and treatment is designed especially for you. We hope that you share this opportunity with people you care about.

### ***Outline of Procedure for New Patients***

All new patients are requested to fill out our comprehensive New Patient Forms. These forms can be completed in our office, or can be downloaded and printed out from our website (here below) to allow you to complete them prior to your first appointment. Some of the questions are what we call “thoughtful”. We ask that you offer the most complete and concise information possible. You will notice that Dr. Dillberg’s emphasis is not only on your symptoms, but also on your priorities and health goals. Together you will make a health plan to help you attain your goals and feel your best.

### ***SCHEDULING APPOINTMENTS:***

Thank you for your interest in our office, and your commitment to better health. We would be very happy to work with you to meet your health goals.

Please call our office to set up an appointment (808) 742-9326. Using email (because we have to go back and forth) could delay you getting the appointment time you need. We look forward to speaking with you, and answering any questions you might have.

### **Missed Appointment Policy**

Because we offer comprehensive treatment, and spend a great deal of time in preparation for each appointment, we require at least 48 hours notice when canceling a new patient appointment (24 hours notice to cancel or change a routine appointment). Our missed appointment fees are 50% of the regular fee for the appointment.

Welcome to the Office of  
**Dillberg Integrated Healthcare**

2711 Ala Kinoaiki - 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 Dr. Dillberg is not a Medicare Provider, and that this office does not participate with PPO, HMO, or Major Medical insurance programs. I understand that a personalized payment program can be arranged for me, and that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

I understand that my participation and adherence to Dr. Dillberg's recommendations are essential for success in this program, and that open and constant communication is necessary. This office will not be held responsible for any health conditions or diagnosis which are pre-existing, given by another healthcare practitioner, or are not related to the conditions diagnosed or treated by this clinic.

\_\_\_\_\_  
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 \_\_\_\_\_

Mailing 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?

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

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The most recent time/what for: \_\_\_\_\_

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

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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:

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

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

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**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 ? \_\_\_\_\_

Please list any supplements (i.e.:vitamins, minerals, herbs) you are currently using: \_\_\_\_\_

## **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 ...?*

\_\_\_ Neck Pain  
\_\_\_ Pain into your shoulders/arms/hands  
\_\_\_ Numbness/tingling into arms/hands  
\_\_\_ Hearing disturbances  
\_\_\_ Weakness in grip  
\_\_\_ Headaches  
\_\_\_ Dizziness  
\_\_\_ Visual disturbances  
\_\_\_ Coldness in hands/feet  
\_\_\_ Thyroid Conditions  
\_\_\_ Sinusitis  
\_\_\_ Allergies/Hay fever  
\_\_\_ Recurrent Colds/flu  
\_\_\_ Fatigue  
Explain: \_\_\_\_\_

THORACIC SPINE (UPPER BACK) *Do you experience... ?*

\_\_\_ Heart palpitations  
\_\_\_ Heart murmurs  
\_\_\_ Tachycardia  
\_\_\_ Heart Attacks/Angina  
\_\_\_ Recurrent lung infections/bronchitis  
\_\_\_ Asthma/Wheezing  
\_\_\_ Shortness of breath  
\_\_\_ Pain on deep inspiration/expiration

THORACIC SPINE (MID BACK) *Do you experience ...?*

\_\_\_ Mid back pain  
\_\_\_ Pain into your ribs/chest  
\_\_\_ Indigestion  
\_\_\_ Heartburn  
\_\_\_ Nausea  
\_\_\_ Ulcers/Gastritis  
\_\_\_ Hypoglycemia  
\_\_\_ Tired/irritable after eating or when you haven't eaten for awhile

LUMBAR SPINE (LOWER BACK) *Do you experience ...?*

\_\_\_ Low back pain  
\_\_\_ Numbness/tingling into your legs/feet  
\_\_\_ Coldness in your legs/feet  
\_\_\_ Muscle cramps in your legs/feet  
\_\_\_ Weakness/injuries in your hips/knees/ankles  
\_\_\_ Pain into your hips/legs/feet  
\_\_\_ Frequent/difficulty urinating  
\_\_\_ Constipation/Diarrhea  
\_\_\_ Menstrual irregularities/cramping (females)  
\_\_\_ Sexual Dysfunction  
\_\_\_ Recurrent bladder infections

Please list any health conditions not mentioned above:

\_\_\_\_\_

# Pain Chart

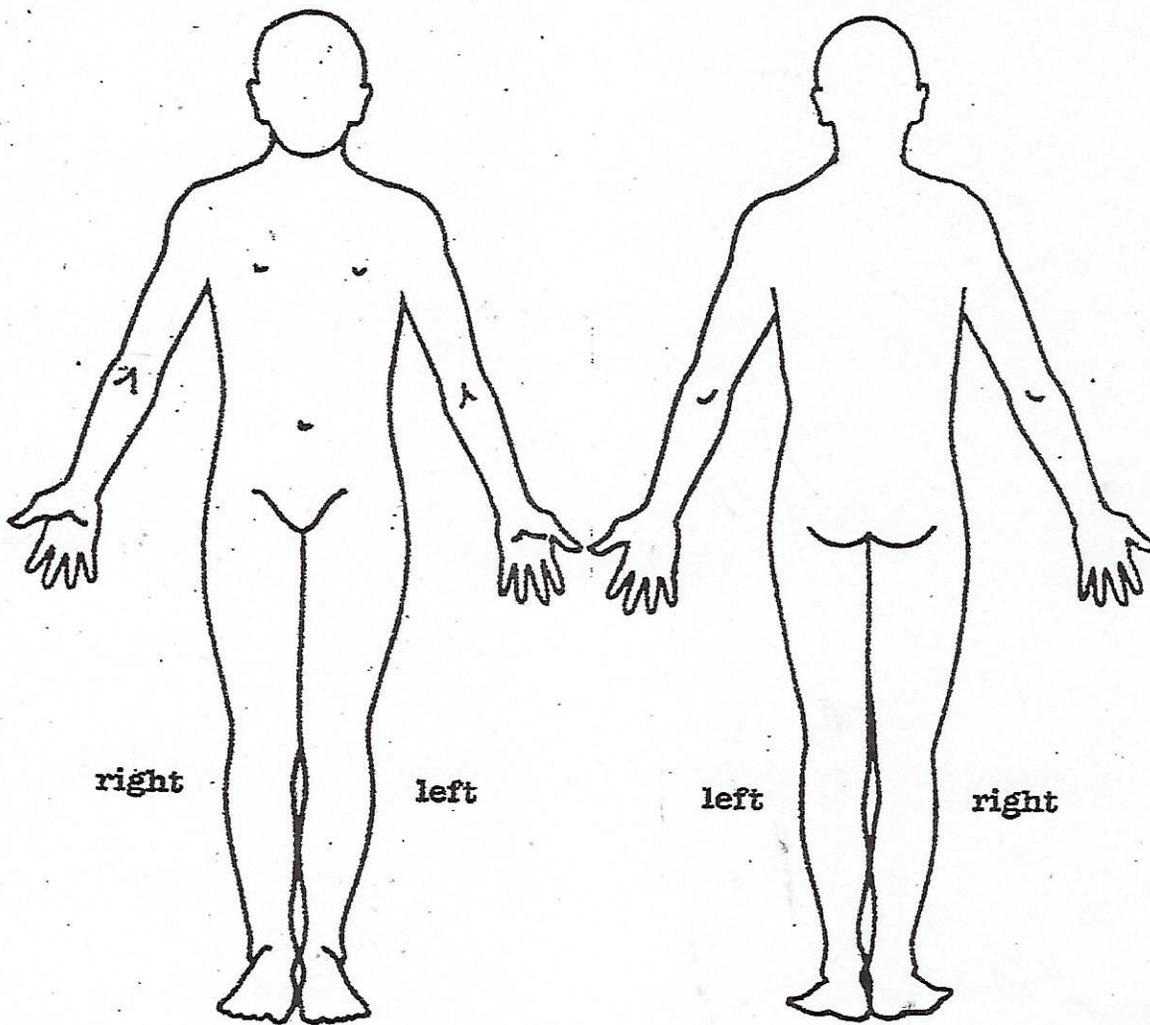
Patient Name \_\_\_\_\_ Date \_\_\_\_\_

This is a Visual Analogue Scale, please help us to understand the location and level of your pain to best be able to help you.

- On a scale of 0 to 10 – 10 being the absolute worst pain imaginable, please mark an X where you feel your pain level is at its worst.

0 \_\_\_\_\_ 3 \_\_\_\_\_ 5 \_\_\_\_\_ 8 \_\_\_\_\_ 10  
NO PAIN                      MILD PAIN                      MODERATE PAIN                      SEVERE PAIN

- Next, on the diagram below indicate where on your body you feel pain or have symptoms. Write the appropriate number from the analog scale for each area of pain or symptom.



Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_