Welcomes You

Full Name: _____Today's Date:_____

DOB:_____ M / F Social Security #:_____ DL#_____

Address: _____ City:_____ State:_____

Zip Code:_____ Home # : _____ Cell #:_____

Occupation: _____ Employer:_____

Emergency Contact: _____ Phone:_____

Referred By: _____ Internet◯ Physician◯ Other:_____

Patient Information_____

Auto Accident Date: _____ Time: _____ AM◯ PM◯

City of Accident: _____ Street of Accident: _____

Road Conditions: Dry◯ Wet◯ Icy◯ Other:_____

Police at scene: Yes◯ No◯ Emergency Services at scene: Yes◯ No◯

Police Report #: _____ Emergency Service Company: _____

Emergency room visited: Yes◯ No◯ Primary Care Provider (PCP) visited: Yes◯ No◯

Hospital Name (ER) :_____ Date of Visit:_____

Primary Care Provider: _____ Date of Visit:_____

Medication(s) Given: _____ X-rays taken: Yes◯ No◯

Number of person(s) in vehicle: _____ Is/are person(s) with you today: Yes◯ No◯ N/A◯

Please describe, in your own words the accident and what happen to the best of your knowledge:

_____

_____

_____

_____

_____

What area(s) suffered injury (Please Circle):

Neck Low Back Head Mid-Back Shoulders Elbows Knees

Stomach Chest Ankles/Foot Other(s) (specify):_____

Where were you seated in the vehicle: Driver ◯ Front passenger ◯ Back Seat L ◯ R ◯

Aware of approaching collision prior to it happening: Yes ◯ No ◯

Wearing a seat belt: Yes ◯ No ◯ Did airbags go off: Yes ◯ No ◯

What direction was your neck turned during the accident: Straight-forward ◯ Left ◯ Right ◯

Any bruises or cuts: Yes ◯ No ◯ If yes, where (specify):_____

Size of your vehicle: Small ◯ Mid-Size ◯ SUV ◯ Truck ◯ Semi ◯

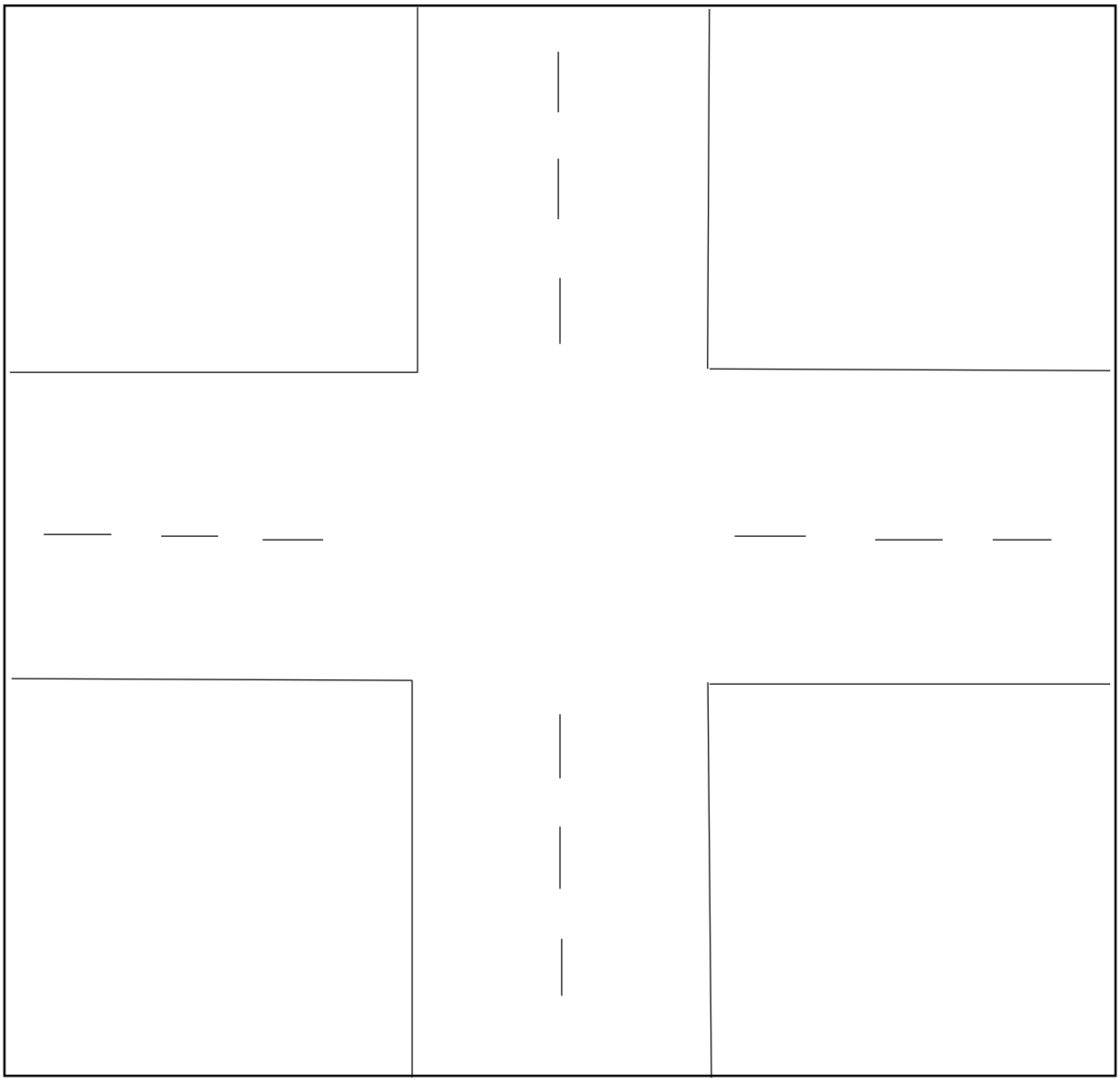
Size of opposing vehicle: Small ◯ Mid-Size ◯ SUV ◯ Truck ◯ Semi ◯

How fast were you going: 5-15mph ◯ 16-30 ◯ 30-50 ◯ 50-60 ◯ 70-above ◯

Stopped ◯ Parked ◯ Backing up ◯

Accident Diagram

Please Use Legend: Your vehicle: **1** Opposing vehicle: **2** Other vehicles: **3-5**



Patient History

Note: The following questions may not seem to relate to your current health problems, but they are very important for the doctor to determine how well you may respond to chiropractic care, physical therapy and in determining the true cause of your problems.

Please check any of the following illness you have or had:

Diabetes ◯	Tuberculosis ◯	Hepatitis ◯	Gout ◯	Hypoglycemia ◯
Pneumonia ◯	Cirrhosis ◯	Crohn's Disease ◯	Thyroid problems ◯	Emphysema ◯
Epilepsy ◯	Celiac Disease ◯	Angina ◯	Asthma ◯	Convulsions ◯
Heart Attack ◯	Rheumatic Fever	Polio ◯	Ulcers ◯	Hemorrhoids ◯
Concussion ◯	Diverticulitis ◯	Lupus ◯	Gallbladder disease ◯	HIV/AIDS ◯
Spinal Cord Injury ◯		Multiple Sclerosis ◯		

Cancer: _____Year: _____ Arthritis: _____

Fractures: _____ Year: _____ Any other serious illnesses: _____

Please check if you had any of the following surgeries (please specify year beside procedure):

Gallbladder Surgery ◯ _____	Hemorrhoidectomy ◯ _____	Tonsillectomy ◯ _____
Colon Surgery ◯_____	Hysterectomy ◯ _____	Breast surgery ◯ _____
Appendectomy ◯_____	Kidney Surgery ◯ _____	Cesarean Section ◯_____
Hernia Surgery ◯_____	Lung Surgery ◯ _____	Bladder surgery ◯ _____
Tubal Ligation ◯_____	Heart Surgery ◯ _____	Vasectomy ◯ _____

Other surgeries (specify): _____

Family History

Please check any of following illnesses your immediate family may have or had:

Heart Disease ◯ Diabetes ◯ Cancer ◯ Type: _____ High Blood Pressure ◯

◯ Genetic disease (Please Specify):_____ Other illnesses (specify):_____

Activities of Daily Living

Daily Work Duties: Lifting over: 15 pounds ◯ 30 pounds ◯ 50 or more ◯

Job Description: _____ Hours: Full ◯ Part-time ◯

Leisure Activities: Work out ◯ Boating ◯ Sports activities ◯

Travelling ◯ Other (specify):_____

Able to perform: Work Duties: Yes ◯ No ◯ Specify if necessary: _____

Leisure activities: Yes ◯ No ◯ Specify if necessary: _____

Current Symptoms and Manifestations

Neck Pain ◯	Back Pain ◯	Headache ◯	Hand/arm numbness ◯
Neck Stiffness ◯	Sleep difficulty ◯	Chest Pain ◯	Leg/foot numbness ◯
Ear ringing ◯	Ear buzzing ◯	Loss of hearing ◯	Nervousness ◯
Memory loss ◯	Tension ◯	Vision blurry ◯	Pins and Needles ◯
Fatigue ◯	Jaw Problems ◯	Light sensitivity ◯	Head seems heavy ◯
Nausea ◯	Anxiety ◯	Eye shakiness ◯	Shortness of breath ◯

Any other symptoms (please specify): _____

_____

Severity of symptoms:

GOOD 1 2 3 4 5 6 7 8 9 10 **WORSE**

Are symptoms getting progressively worse: Yes ◯ No ◯

Do symptoms: Come and Go ◯ Are Constant ◯

Type of pain: Sharp ◯ Dull ◯ Throbbing ◯

Achy ◯ Burning ◯ Shooting ◯

Do symptom(s) interfere with daily activities: Yes ◯ No ◯

Activities that you are unable to perform:

Sitting ◯	Standing ◯	Walking ◯	Lifting ◯
Bending ◯	Lying Down ◯	Squatting ◯	Turning head ◯

Additional activities not listed (specify): _____

I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Insurance Information

3rd Party Auto Insurance Information (Party at fault)

Name of Driver: _____ Name of Owner:_____

Type of Vehicle: _____ License Plate #:_____

Insurance Company: _____ Claim #:_____

Claim Adjuster: _____ Policy #: _____

Phone#: _____ Fax #: _____

Your Auto Insurance Information

Insured Name: _____ Policy # _____

Insurance Company: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Claim #: _____ Phone #: _____

PIP (Personal Injury Protection): Yes ◯ No ◯ Amount (PIP):_____ Med-Pay: Yes ◯ No ◯

Medical Coverage Maximum: _____ Uninsured Motorist Coverage: Yes ◯ No ◯

Health Insurance Information- Please provide a copy of policy card to front desk for compliance purposes.

Insured Name: _____ Employer: _____

Insurance Company: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax #: _____

Policy #:_____ Group #: _____

Informed Consent to Examination and Treatment

I (we) hereby consent to the implementation of an examination and treatment on me or on the minor, _____, by the licensed Doctor of Chiropractic, medical doctors, or licensed physical therapists who may be employed by or engaged in practice at Texas Spine and Joint Rehabilitation.

I have had an opportunity to discuss with the doctor, and or other clinic personnel the nature and purpose of the physical therapy procedures and chiropractic procedures. I understand that neither chiropractic, nor medical treatment is an exact science and that my care may involve judgments based upon facts and information identified by the doctor. The doctor uses this judgment to anticipate risks and complications, therefore an undesirable result which is rare, does not necessarily indicate an error in judgment. No guarantee of results can be made or expected, but I wish to rely on the doctor to choose and recommend the best course of treatment based upon the facts identifiable and what is in my best interests.

I further understand that there is a certain degree of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain / sprains. I am therefore, willing to accept and consent to the risks associated with the care that I am about to receive.

I have read the above information regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and give full consent to receive the procedures prescribed for my condition and understand the possible future complications for which I seek treatment.

Female patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.
Date of Last Menstrual Period: _____.

_____ _____

Patient Printed Name Patient Signature

_____ _____

Date Relationship or Authority
Guardian if not signed by patient

_____

Witness

Texas Spine and Joint Rehabilitation

208 W. Kearney, Suite 102

Mesquite, Texas 75149

THIS NOTICE PERTAINS TO PRIVACY MEASURES TO ALL DOCTORS
OPERATING AT TEXAS SPINE AND JOINT REHABILITATION.

PATIENT CONSENT FOR USE/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

With my signature below, I give consent for the doctor (the practice) to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment and healthcare operations.

I have reviewed the privacy policy of this practice prior to signing this consent. The privacy policy may be amended from time to time, and I may always obtain a copy of the current policy without change by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While the practice is not required to agree to restrictions, the practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The practice may communicate confidential information to me, included any invoices for services, at the following address/phone number/fax number/ email address:

Address: _____ Phone: _____

Email: _____ Fax #: _____

_____ _____

Patient/Patient representative Signature

Date