



Welcomes You

Full Name: _____ Today's Date: _____
DOB: _____ M / F Social Security #: _____ DL# _____
Address: _____ City: _____ State: _____
Zip Code: _____ Home # : _____ Cell #: _____
Email: _____ Marital Status: Married Single
Occupation: _____ Employer: _____
Emergency Contact: _____ Phone: _____
Referred By: _____ Internet Physician Other: _____

What Brings You In For Care?

What is your major complaint today? _____

Any additional problems or comments? _____

- Check here if you are here with no current complaints and are seeking preventive and maintenance care.
 - Check here if you have had chiropractic care before. Doctor: _____
 - Check here if you are interested in wellness and or supplementation options
-

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

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: _____

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 #: _____

Insurance Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Texas Spine and Joint Rehabilitation, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Name (Printed)

Date

Patient Signature

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 charge 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