TEXAS CHIROPRACTIC WELLNESS

INFORMATION/APPLICATION FOR CARE

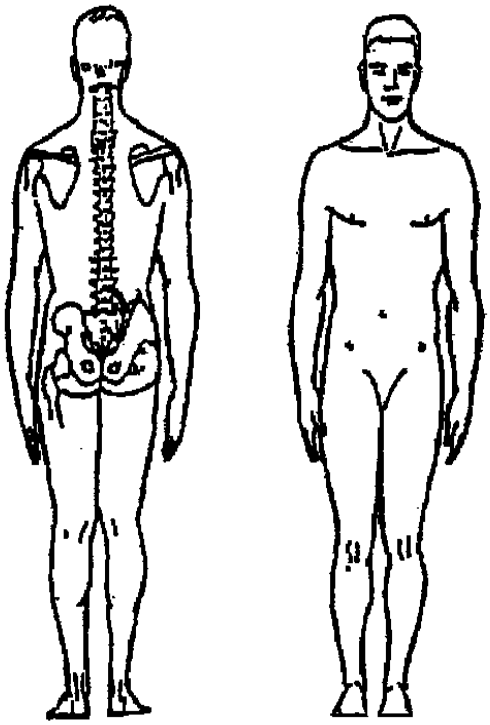
The following information is needed in order to better serve you. Please complete all questions. If you need help please ask .

Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc……

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

_____
_____
_____
_____
_____
_____
_____

How did you hear about our office?: _____

Do you have Medicare? Yes No

Please circle one payment type: Cash Check Master Card/Visa

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of this visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Patient Case History

Please complete this questionnaire..

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you *now* have or *have* had previously.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C
GENERAL
☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Depression
☐ ☐ ☐ Tremors

MUSCLE & JOINT
☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain/stiffness
☐ ☐ ☐ Mid-back pain
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Poor posture

PAIN OR NUMNBESS IN:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Tail bone

O F C
GASTRO-INTESTINAL
☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE &THROAT
☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

O F C
CARDIO-VASCULAR
☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY
☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Wheezing

SKIN
☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

URINARY
☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Kidney infection
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble

FOR WOMEN ONLY
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopause symptoms
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Gout	☐ MS	☐ Tuberculosis
☐ Appendicitis	☐ Eczema	☐ Heart disease	☐ Mumps	☐ Typhoid fever
☐ Arthritis	☐ Emphysema	☐ Influenza	☐ Pleurisy	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Pneumonia	☐ Whooping cough
	☐ Fever blisters		☐ Polio	

PLEASE PRINT

List previous surgical operations and years: _____
_____

Drugs you now take: ☐ Steroids ☐ Pain killers ☐ Muscle relaxers ☐ Sleeping drugs ☐ Birth control
Others: _____

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never
Describe: _____

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? _____

Have others in your family had such disorders? ☐ Yes ☐ No When? _____

HAVE YOU EVER:	Yes	No	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____

DATE OF LAST:	0-6 months	6-18 months	18+ months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X- ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

TEXAS CHIROPRACTIC WELLNESS

Office Financial Policy

Fee for Service

1. All patients are responsible to pay for their care
2. First day services are to be paid in full unless arrangements have been made prior to services rendered.
3. This office may make payment plan arrangements on an individual basis. Any such plans or arrangements will be discussed during your final report.

Other Coverage

1. We do not accept assignment for Major Medical Companies (Insurance Coverage). We will provide a receipt for you to file with your insurance company, if you so choose. This information is accepted by most insurance companies.
2. The patient is responsible to pay for services rendered regardless of their insurance company's failure to pay for the services for any reason. We are not a mediator between the patient and their insurance company and will not enter into any dispute with them, as the patient's contract is between the patient and their insurance company.
3. If the patient is referred to a specialist or discontinues care for any reason other than being discharged by the doctor, payment for services rendered are due in full.

If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.

Thank you

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patients or Guardians Signature Date

Personal Preferences and Treatment Options

Our primary goal is to meet or exceed your expectations every time you visit our office. We would like to know what you like or dislike so we can care for you in a manner in which you are comfortable. Therefore, we would like for you to answer the following questions. Please mark the statements that apply to you with a "×" or a "✓".

I *have been* to a Doctor of Chiropractic before and had the following experience:

- The doctor used a hands-on or manual technique that involved the joints of the spine making a noise when adjusted and I was pleased with the experience.
- The doctor used a hands-on or manual technique that involved the joints of the spine making a noise when adjusted and I was not pleased with the experience.
- I would be interested in spinal adjustments that involve a gentle percussion of the spinal joints.
- I have no opinion to offer – I wish to follow whatever methods the doctor deems appropriate for the care of my condition.

I *have never* been to a Doctor of Chiropractic before, but I have an idea about what I would prefer:

- I like the idea of the joints of the spine making a noise when adjusted.
- I do not feel comfortable with the idea of the joints of the spine making a noise when adjusted.
- I would be interested in spinal adjustments that involve a gentle percussion of the spinal joints.
- I have no opinions to offer – I wish to follow whatever methods the doctor deems appropriate for the care of my condition.

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic adjustments and other therapies on me (or on the patient for whom I am responsible for) while in this clinic.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of care which the doctor feels at the time, based on the facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any further condition(s) for which I seek treatment.

Patients Signature:_____ Date:_____

Guardians Signature:_____ Date:_____