



## PATIENT INFORMATION

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

Patients Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Physical Address \_\_\_\_\_  
First Middle Last City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Circle YES / NO to sign up for our newsletter!

Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ No. of Children \_\_\_\_\_ Marital Status: S M D W

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouses Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

### PHONE NUMBERS

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Nearest relative NOT living with you  
Name \_\_\_\_\_

Home # \_\_\_\_\_

Cell # \_\_\_\_\_

Nearest friend NOT living with you  
Name \_\_\_\_\_

Home # \_\_\_\_\_

Cell # \_\_\_\_\_

### ACCIDENT INFORMATION

Is this due to an accident? YES NO

Type of Accident  
(circle one)

Auto Work Home Other

Who have you reported this accident to?

Auto Ins \_\_\_\_\_ Employer \_\_\_\_\_ Other \_\_\_\_\_

Attorney's Name \_\_\_\_\_

### How did you hear about us?

Internet \_\_\_\_\_ Insurance \_\_\_\_\_ Walked by \_\_\_\_\_ Referral \_\_\_\_\_ Other \_\_\_\_\_

# **HEALTH HISTORY**

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Please check all the appropriate boxes for any of the following symptoms which you now have or have had previously. It is very important that we have all the facts about your health before we treat you. **THIS FORM IS CONFIDENTIAL.**

- |   |  |   |   |   |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Allergy Shots      | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herniated Disc     | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Depression          | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors, Growths    |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Gout                | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever        | _____                                       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Stroke               | _____                                       |

Please list any medications or supplements that you are currently taking \_\_\_\_\_

Are you allergic to any medication? (please list) \_\_\_\_\_

Have you ever been hospitalized? (describe) \_\_\_\_\_

Had surgery?  YES  NO Please Describe: \_\_\_\_\_

Have you ever seen a chiropractor before?  YES  NO If YES, who & when? \_\_\_\_\_

Did it help?  YES  NO

Describe your NORMAL work activity:  SITTING  STANDING  LIGHT LABOR  HEAVY LABOR

**HABITS**

Smoking-  YES  NO # per day \_\_\_\_\_ How long \_\_\_\_\_

Alcohol-  YES  NO # per day \_\_\_\_\_ How long \_\_\_\_\_

Caffeine-  YES  NO # per day \_\_\_\_\_ How long \_\_\_\_\_

**FAMILY HISTORY**

	Diabetes	Heart	Kidney	Cancer	Back
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Date of last medical exam? \_\_\_\_\_

**Are you pregnant?**

YES  NO Due Date \_\_\_\_\_

**Nursing?**

YES  NO

**Birth Control?**

YES  NO

**Please circle your stress level:**

Low 1 2 3 4 5 High Cause: WORK FAMILY FINANCIAL PAIN OTHER \_\_\_\_\_

Do you exercise?  NONE  OCCASIONALLY  DAILY Intensity?  Light  Moderate  Intense

How would you describe your diet and eating habits? \_\_\_\_\_

**TELL US WHY YOU ARE HERE TODAY**

Reason for visit \_\_\_\_\_ When did symptoms first appear? (date) \_\_\_\_\_

Is there any specific activity or event that caused your pain? \_\_\_\_\_

Which activities are difficult to perform?  Sitting  Standing  Walking  Bending  Lying down  Other

Have you ever experienced similar symptoms in the past?  YES  NO How long ago? \_\_\_\_\_

Does anything make it feel better? \_\_\_\_\_ Worse? \_\_\_\_\_

Type of pain:  Sharp  Dull  Aching  Throbbing  Numbness  Shooting  Tingling  
 Stiffness  Burning  Swelling  Cramps  Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_ Is it constant or does it come & go? \_\_\_\_\_

Does the pain radiate/travel to different areas?  YES  NO Where else do you feel it? \_\_\_\_\_

As a result of your symptoms, are you restricted in your ability to perform work and/or daily activities?  YES  NO

Please describe \_\_\_\_\_

Do you have any other symptoms that you feel are associated with your current condition? \_\_\_\_\_

What treatment have you received for this condition?  Chiropractic  Physical Therapy  Surgery  Medication

Have you ***ever*** had x-rays taken?  YES  NO Body location of X-ray \_\_\_\_\_

List any accidents and/or falls and their dates:

Falls: \_\_\_\_\_

Motor Vehicle: \_\_\_\_\_

Sports: \_\_\_\_\_

Other: \_\_\_\_\_

List any broken bones or dislocations: \_\_\_\_\_

Have you ever had any spinal taps or spinal injections?  YES  NO When? \_\_\_\_\_

Have you ever been knocked unconscious?  YES  NO When? \_\_\_\_\_

Have you ever had a lapse of memory?  YES  NO When? \_\_\_\_\_

Do you suffer from any other condition other than that for which you are now consulting us? \_\_\_\_\_

## **Services Rendered Agreement**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I am fully responsible for all charges due for services rendered. All charges must be paid at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

## **CONSENT FORM**

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, cold application, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back.

*I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.*

---

Patient signature

Date

Please read the following carefully and initial each statement.

- |       |  |
|-------|--|
| <hr/> | I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the chiropractic physician because it may affect care.   |
| <hr/> | I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, HTX Chiropractic reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans. |

# **Notice: Patient Privacy**

## **How Medical Information About You May Be Used and Disclosed and How You Can Access This Information.**

We are committed to protecting the privacy of your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996, we are required by law, to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide, and related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information and/or records for other purposes without your consent or authorization.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our notice from time to time. The effective date is the date signed and indicates the date of the most current notice in effect.

You have a right to receive a copy of our most current notice in effect. If you have not yet reserved a copy of our current notice, please ask the front desk and we will provide you with our most current copy.

If you have any questions, concerns or comments about the notice or your medical information, please contact our office at (281)251-4400.

---

Signature

---

Date

---

Printed patient name