WOODLANDS CHIROPRACTIC

Patient Information

Date_____

First Name: _____Last Name: _____Middle Initial: _____

Major Complaint Information

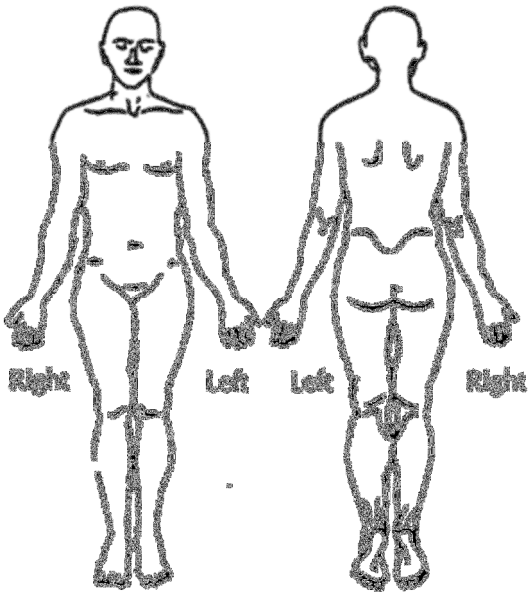
What is/are your major complaint(s)? _____

_____

When did the symptom(s) begin?_____

If this is an injury, describe what happened? _____

Using the symbols provided in the Pain Index box, mark the areas of the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)



Pain Index

D	Dull Nagging Ache
B	Burning
S	Sharp / Stabbing
N	Numbness / Tingling

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "**B8**" on the neck of the illustration

Have you experienced these symptoms before? ❍Yes ❍No When? _____

What aggravates this condition?_____

What decreases the symptoms / pain? _____

Have you seen another doctor for this condition? ❍Yes ❍No Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? ❍Yes ❍No If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ❍Back ❍Side ❍Stomach

Do you sleep with a pillow? ❍Yes ❍No How many? _____

Does heat affect the pain? ❍Yes ❍No If so, how? _____

Does cold affect the pain? ❍Yes ❍No If so, how? _____

Do you wear a heel lift? ❍Yes ❍No If so, which side? ❍Right ❍Left

Does it cause pain to cough, grunt, or sneeze? ❍Yes ❍No If so, where? _____

_____

Check those activities below during which you experience difficulty or pain:

❍Lying on back	❍Lying on side	❍Turning over in bed	❍Lying flat on stomach
❍Getting in/out of car	❍Dressing Self	❍Sexual Activity	❍Pushing
❍Pulling	❍Reaching	❍Kneeling	❍Stooping
❍Sitting	❍Bending forward	❍Bending backward	❍Walking
❍Standing for long periods	❍Sneezing	❍Coughing	❍Other_____

FILL OUT THE NEXT THREE SECTIONS AS THEY APPLY TO YOU

Lower Back Pain

Does pain radiate into the leg? ❍Yes ❍No If so, where?_____
Does pain radiate to the abdomen? ❍Yes ❍No
Do you ever have impairment of bowel or urinary function? ❍Yes ❍No Explain:_____
Do you have numbness or tingling into the legs? ❍Yes ❍No Explain:_____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) ❍Hearing ❍Vision ❍Balance ❍Cause ringing in ears
Do you hear grating sounds? ❍Yes ❍No Do you feel pressure behind your eyes? ❍Yes ❍No
Does pain radiate into the arm? ❍Yes ❍No Where: _____
Do you have difficulty lifting or turning your head: ❍Yes ❍No (If so, in which direction?) ❍Right ❍Left ❍Up ❍Down

Headaches

Do you get headaches? ❍Yes ❍No Frequency_____ Do you have a family history of headaches? ❍Yes ❍No
Do you experience the following along with your headaches: Pain or cracking in your jaw? ❍Yes ❍No
Abnormal blood pressure? ❍Yes ❍No ❍High ❍Low Nausea, Vomiting, or Visual disturbances? ❍Yes ❍No
When was your last eye exam by a doctor? ❍1-6 months ❍6-12 months ❍1-2 years ❍over 2 years Results _____

If female, are you pregnant? ❍Yes ❍No ❍Not Sure
If not sure, date of your last menstrual period:_____
List of all medications you are taking now, including over the counter medication:_____
_____
Are you allergic to any medications? ❍Yes ❍No ❍Not Sure Please list:_____
Have you ever had any surgeries or hospitalizations? ❍Yes ❍No (Please list below)

Type of Hospitalization/Surgery:	Date:	Type of Hospitalization/Surgery:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? ❍Yes ❍No When?:_____
Have you ever been seen by a chiropractor before? ❍Yes ❍No (Please list below)

Name of Chiropractor:	Dates:	Name of Chiropractor	Dates:
_____	_____	_____	_____

Do you have a family physician? ❍Yes ❍No
Name of physician:_____ Phone:(_____)_____
Address:_____
City/State/Zip:_____

Do you have, or have you ever had, any diseases or medical problems not listed? ❍Yes ❍No
If so, please list: _____
Have you ever had? ❍Motor Vehicle Injury ❍Sports Injury ❍Work Injury ❍Slip and Fall Injury
If yes, please explain: _____
Any additional information you would like the doctor to know about before beginning care at Woodlands Chiropractic: _____
_____

Please check all additional complaints that you have at this time:

❍Loss of Concentration
❍Anxiety
❍Dizziness
❍Shortness of Breath
❍Memory Loss
❍Heavy Feeling of Head
❍Depression
❍Insomnia
❍Fatigue
❍Nervousness
❍Eyes Sensitive to light
❍Irritable
❍Cold Hands
❍Cold Feet

❍Ringing in Ears
❍Pain Behind Eyes
❍Jaw Pain
❍Neck Pain/Stiffness
❍Upper Back Pain/Stiffness
❍Mid Back Pain/Stiffness
❍Right/ Left Shoulder Pain
❍Right/ Left Arm Pain
❍Low Back Pain/Stiffness
❍Right/ Left Leg Pain
❍Pins/Needles Arms/Legs
❍Numbness
❍Convulsions
❍Fainting

❍Excess Perspiration
❍Vision Problems
❍Loss of Balance
❍Loss of Smell
❍Loss of Taste
❍Digestive Trouble
❍Nausea
❍Constipation
❍Vomiting
❍Diarrhea
❍Anemia
❍Bruising
❍Arthritis
❍Swelling

❍Cuts (list)_____
❍Palpitation
❍Chest Pain
❍HIV (Aids)
❍Heart Disease
❍Hypertension
❍Diabetes
❍Sinus Trouble
❍Allergies (list)
_____
_____
❍Other (Please List)
_____
_____

Personal Information

Name: _____
Address: _____
City / State / Zip: _____
Home Phone: (_____)_____ Work Phone: (_____)_____
Mobile Phone: (_____)_____ Email:_____
Social Security #:_____ Birth Date: _____ Age: _____ Sex: ❍M ❍F
Occupation: _____ Employer's Name: _____
Work Address: _____
City / State / Zip: _____
Marital Status: ❍**S** ❍**M** ❍**D** ❍**W** Spouse's Name:_____ # of Children:_____
Please check one: ❍Smoker ❍Non-smoker ❍Tobacco user
How were you referred to Woodlands Chiropractic? _____

Emergency Contact

Name: _____ Relation: _____
Home Phone: (_____)_____ Work Phone: (_____)_____
Address: _____

Insurance Information

Insurance Company: _____ID#:_____
Group #:_____ Insurance Company Phone #: (_____)_____
Insurance Company Address: _____
Policy Holder Name: _____
Policy Holder's Birth Date: _____ Policy Holder's Employer: _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Personal Injury

Date of Accident:_____ Hour_____ ❍AM ❍PM Location_____
How did the accident occur? ❍Auto Collision ❍ On-the-job-injury ❍ Other: _____
Please describe the accident:_____
If work related, did you report the injury to your foreman or employer? ❍ Yes ❍ No
If work related, name and phone number of foreman or authorized person:_____
If auto accident were you? ❍ Driver ❍ Passenger ❍ Pedestrian
If auto collision, were you struck from? ❍ Behind ❍ Right Side ❍ Left Side ❍ Front ❍ Auto was parked
If auto accident, did your car strike the other(s) involved? ❍Yes ❍ No
Or did the other car strike yours? ❍ Yes ❍No ❍ Undetermined Did your vehicle's airbags deploy? ❍ Yes ❍ No
Were you wearing a seat belt? ❍ Yes ❍ No Did anybody strike any objects in the car? ❍ Yes ❍ No
List object(s) struck:_____ Lost work time ❍ Yes ❍ No If yes, date you returned to work_____
Do you have an attorney who has advised you in this case? ❍ Yes ❍ No Attorney Name: _____
Attorney's Address: _____

Authorization & Assignment

I authorize Woodlands Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.
I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you, Woodlands Chiropractic.
I, the undersigned, do hereby appoint Woodlands Chiropractic authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. 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 will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Patient's Signature:_____ Date:_____

Informed Consent

I hereby authorize physicians at Woodlands Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.
I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Woodlands Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.
Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.
Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.
Specific Risk Possibilities Associated with Chiropractic Care:
Soreness– Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.
Soft Tissue Injury– Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft-tissue injury.
Rib Injury– Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.
Physical Therapy Burns– Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.
Stroke– Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.
Other Problems– There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.
If you have any question concerning this form or the above statements, please ask your doctor.
Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient's Signature:_____ Date:_____