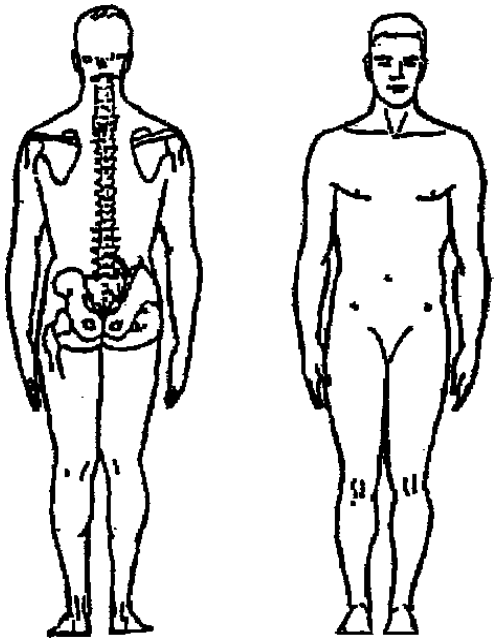
PLEASE BRING A COPY OF YOUR CURRENT LAB WORK

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

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 _____
Your Social Security #_____Weight_____Height _____
Your Employer_____Occupation_____Years On Job _____
Employer Address_____City_____State_____Zip_____
Name of Spouse or Parent_____Their Phone Number_____Their Birthdate _____
Referred to our office by: _____

Please describe your major concerns and mark them on the diagram →

_____
_____
_____



A. Description
- ☐ Sharp/Stabbing Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Weak
- ☐ Throbbing
- ☐ Cold
- ☐ Burning
- ☐ Numb
- ☐ Shooting
- ☐ Gripping
- ☐ Cramping
- ☐ Tingling

Other:_____

B. Frequency
- ☐ Constant (75-100%)
- ☐ Frequent (51 - 75%)
- ☐ Occasional (25 - 50%)
- ☐ Intermittent (25% or less)

C. How long have you been experiencing these symptom(s)
- ☐ Days ☐ Months
- ☐ Weeks ☐ Years
- How many? _____

D. On the scale below indicate the intensity of your pain at its lowest and highest level:

1 2 3 4 5 6 7 8 9 10

E. What do <u>you think</u> is causing your problems? _____
F. Your symptoms are:_____decreasing _____not changing_____increasing
G. Symptoms are worse in the:_____Morning_____Night_____Increases during the day_____Same all day
H. What makes your symptoms better? _____
I. What makes it worse?_____
J. Is your condition due to an accident? Yes_____No_____ Date of accident? _____
K. Type of accident? Auto_____ Work/On Job_____ At Home_____ Other _____
L. Have you ever been in an auto accident? Past Year_____Past 5 Years_____Over 5 Years_____Never _____

<u>On the scale below indicate how serious you are about taking care of your health.</u>

1 2 3 4 5 6 7 8 9 10

AUTHORZATION FOR CARE

I hereby request and consent to the performance of the chiropractic evaluation, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now, or in the future, work at the clinic or office listed above or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I consent to the performance of the chiropractic treatments and/or other functional therapies that are recommended by the doctor.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and equipment use, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, burns and or inflammation. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, 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 content, 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 and for any future condition(s) for which I seek treatment.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I

will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

To the best of my knowledge I am NOT pregnant and the above-named Doctor has my permission to x-ray me for diagnostic interpretation

OFFICE FINANCIAL POLICY

- Payment is due the day service is provided unless other payment arrangements have been made with staff.
- Please communicate with the front desk staff whether you will be filing claims to an insurance company, and present your current insurance card to the front desk. If at any time you change insurance companies, please notify the front desk immediately to update your records.
- **Our doctor is not in any one network. There may be out-of-network coverage through your policy. Our staff will be happy to check with your insurance company to find out the coverage under your plan. Any quote of eligibility and benefits is not a guarantee of payment. (Please note some services and/or procedures may be elective services to which insurance providers do not cover.)**
- We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to directly contact your insurance company, adjustor, or agent. Your insurance is an agreement between you and your insurance company.
- If the patient discontinues care for any reason or completes care, payment is due in full on all services rendered.
- In accordance with Medicare Law, our office cannot give any special promotions or offers to patients who receive Medicare benefits.
- **Please note that appointments that are considered "no-call-no-shows" or are not rescheduled at least two hours prior to appointment time will be subject to a $35.00 cancellation/rescheduling fee.**

I have read and understand both the Consent to Treatment and Office Financial Policy and agree to abide by these terms

Patient's Name Printed	Date	Patient's signature	Date
Minors Name	Guardian/Spouse's Signature of Authorizing care for minor		Date

Falls Clinic of Chiropractic's Doctor and employees will safeguard, according to strict standards of security and confidentiality, any information we collect, receive or maintain about Falls Clinic of Chiropractic's patients. Falls Clinic of Chiropractic maintains administrative, technical, and physical safeguards to ensure the security and confidentiality of our patient information and records, to protect against anticipated threats or hazards to such records, and to protect against unauthorized access to or use of such information or records.

Internally, Falls Clinic of Chiropractic limits access to our patient's information to only those Doctors and employees who need access to the information to perform their job functions. Doctors and/or employees who misuse information are subject to disciplinary actions. Externally, we do not disclose patient information to any third parties unless we have previously informed the patient of the disclosure, have been authorized to do so by the patient, or are required or permitted to make the disclosure by law or our regulations.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OFPRIVACY

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

HIPAA Release Form

I authorize the release of information including the diagnosis, records, examinations rendered to me, and claims information. This information may be released to the following people (please provide their names and relation):

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

Messages from Falls Clinic of Chiropractic

Please call:

[ ] my cell_____
[ ] my work_____
[ ] my home_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

I,_____(print name), acknowledge receipt of Falls Clinic of Chiropractic's Confidentiality and Security form and I acknowledge that I have been offered a copy of this office's Notice of Privacy Practices. This copy will be kept in my patient folder.

_____ _____

Patient Signature **Date**

In case of emergency

Name_____Relationship_____
Best Number to Reach Them:_____Second Best Number:_____

FALLS CLINIC OF CHIROPRACTIC - CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: Please complete this questionnaire -. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ **Date** _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. If you don't have the condition you may leave it blank.
THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness/depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble

☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulders
Pain or numbness in:
☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tailbone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal Curvature
☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ 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
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Earnoises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ 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
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

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

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ Chorea
☐ Scarlet fever
☐ Stroke
☐ Cold sores
☐ Diabetes
☐ Diphtheria
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Tuberculosis
☐ Typhoid fever
☐ Goiter
☐ Gout
☐ Heart disease
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Ulcers
☐ Venereal disease
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Whooping cough

Do you have a pacemaker: ☐ **Yes** ☐ **No**

Do you take blood thinner medication: ☐ **Yes** ☐ **No**

Has your Gallbladder been removed ?: ☐ **Yes** ☐ **No**

Have you been diagnosed with diabetes? ☐ **Yes** ☐ **No** **If yes, what is your A1C level?**_____

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

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

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?	☐	☐	_____

NAME OF YOUR PRIMARY CARE PHYSICIAN AND LOCATION: _____

_____

MAY WE CONTACT THEM WITH UPDATES REGARDING YOUR TREATMENT? Y N

Have you had a recent blood test done in the last 6 months? Y N When:_____ (Please bring a copy of test results to your visit.)

Have you had an EMG performed on your arms or feet? Y N - When: _____

Please list below any serious medical conditions you have had:

_____

_____

How many doctors have you seen for this condition?_____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

_____

_____

_____

Please list below any surgeries you've had?

_____

_____

_____

_____

Has what you've done to date for your condition helped?

☐ Yes, a lot ☐ Yes, some ☐ No, not at all ☐ Indifferent

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? Please be specific.

1._____

2._____

3._____

4._____

5._____

What is your honest vision of your future and/or biggest fear if this condition continues to progress?

_____

_____

What would be different &/or better in your life without this problem? Please be specific.

_____

_____

_____

_____

Falls Clinic
OF CHIROPRACTIC, PLLC

1607 Brook Avenue
Wichita Falls, TX 76301
P: 940.692.1522
F: 940.692.1408

AUTHORIZATION FOR REQUEST FOR INFORMATION

I hereby authorize Falls Clinic of Chiropractic, PLLC, and any of its appointed assistants to obtain the following information from the healthcare record for office notes, x-ray reports, MRI reports, lab test result, CD(s) containing images, photographs or other images, complete healthcare record or other needed information.

I understand that this authorization is valid for 12 months after the date signed, unless canceled by me in writing. This authorization must be dated subsequent to the period for which the information is requested.

I have read and understand the above statements and do expressly and voluntarily consent to disclosure of the above information to those persons or agencies named above. I hereby release Falls Clinic of Chiropractic, PLLC and any of its appointed assistants from all legal responsibility or liability that may arise from the release of these healthcare records.

_____ _____

Print Name Date

_____ _____

Signature Date