PATIENT DEMOGRAPHIC INFORMATION

Last name: _____ First name: _____Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Occupation: _____ Employer: _____

Social Security: _____ Age: _____ Date of birth: _____

Gender: [ ] Male [ ] Female Status [ ] Single [ ] Married [ ] Divorced [ ] Widowed Height____Weight____

Race: (Circle one) American India or Alaska Native/ Asian/ Black of African American/ White (Caucasian)/ Native Hawaiian or Pacific Islander/ Other/ I decline to answer

Ethnicity: (Circle one) Hispanic or Latino/ Not Hispanic or Latino/ I decline to answer

CMS requires providers to report both race and ethnicity

Preferred language: _____

E-mail address: _____

Spouse's name: _____

Spouse's employer: _____

Spouse's work phone: _____

Other nearest relative or contact person: _____ Phone: _____

Have you received chiropractic care in the past? [ ] Yes [ ] No

Name of your medical doctor: _____

Complete if applicable to your current condition: [ ] personal injury [ ] auto accident [ ] worker's comp

If you have consulted an attorney regarding the above, please provide your attorney's name, address, and phone number: _____

How did you hear about our office? _____

Signature Date

107 N. CEDAR RIDGE DR. STE 134 DUNCANVILLE TX 75116 P: 972-298-2649 F: 972-692-5785
ELITESPINEDFW@GMAIL.COM ELITESPINEDFW.COM

Health History

Patient: Date: Number:

Do you have any of the following? Mark all that apply.

[ ] Chest pain	[ ] A sore that does not heal	[ ] Pain that wakes you from a sound sleep	[ ] Blurred vision
[ ] Night sweats	[ ] Change in bowel/bladder habits	[ ] Drooping eyelid or change in pupils	[ ] Double vision
[ ] Dizziness	[ ] Unusual bleeding or discharge	[ ] Thickening in breasts or elsewhere	[ ] Nausea or vomiting
[ ] Headaches	[ ] Pain in neck, jaw, or face	[ ] A wart or mole that is changing	[ ] Slurred speach
	[ ] Nagging cough or hoarseness	[ ] Ringing in your ears	[ ] Visual disturbances

Please answer the following questions by marking yes or no

Do you pass out easily or faint? [ ] Yes [ ] No

Do you take birth control pills? [ ] Yes [ ] No

Are you pregnant? [ ] Yes [ ] No

Are you losing weight without trying? [ ] Yes [ ] No

Are you coughing up blood or noticing it in your stools or urine? [ ] Yes [ ] No

Have you lost consciousness or had double vision recently? [ ] Yes [ ] No

Do you take blood thinners? [ ] Yes [ ] No

Do you currently have, or have ever had any of the following? Mark all that apply.

[ ] High blood pressure	[ ] Asthma	[ ] Ulcer or stomach problems	[ ] Thyroid disease
[ ] Heart attack	[ ] Diabetes	[ ] Stroke	[ ] Circulation problems
[ ] Seizures/ convulsions	[ ] Kidney disease	[ ] Arthritis	[ ] Cancer
[ ] HIV/ AIDS	[ ] Pacemaker	[ ] Mental illness	[ ] Osteoporosis

If female, what was the date of the onset of your last menstrual cycle? _____

Are you currently taking any medications (prescription and/ or over the counter) [ ] Yes [ ] No If yes, please list medication, dosage, and frequency. _____

Are you seeing any other doctor for any other reason? [ ] Yes [ ] No If yes, please explain: _____

Have you ever had any major traumas, broken bones, or fractures? [ ] Yes [ ] No If yes, please list what and date: _____

_____

Do you have any medication allergies or any other allergies? [ ] Yes [ ] No If yes, please list: _____

_____

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SOCIAL HISTORY:

Do you smoke or use tobacco products? [ ] Every Day [ ] Occasional [ ] Former [ ] Never

Do you drink alcohol? [ ] Yes [ ] No If yes, how much? _____

Do you drink coffee? [ ] Yes [ ] No If yes, how much? _____

Do you exercise? [ ] Yes [ ] No If yes, how often? _____

How would you rate your diet? [ ] Poor [ ] Fair [ ] Good [ ] Excellent

FAMILY HISTORY

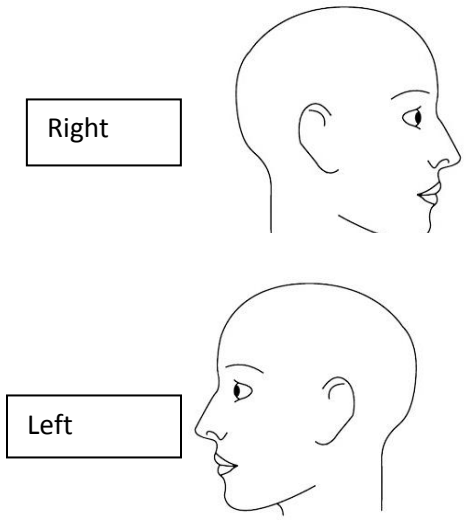
Have your family members (grandparents, parents, siblings, children) had any of the following? Mark all that apply.

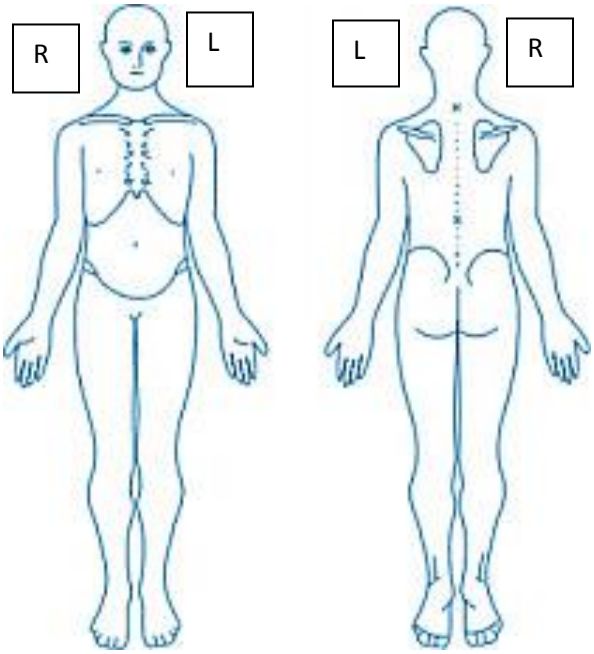
[ ] High blood pressure	[ ] Asthma	[ ] Ulcer or stomach problems	[ ] Thyroid disease
[ ] Heart attack	[ ] Diabetes	[ ] Stroke	[ ] Circulation problems
[ ] Seizures/ convulsions	[ ] Kidney disease	[ ] Arthritis	[ ] Cancer
[ ] HIV/ AIDS	[ ] Pacemaker	[ ] Mental illness	[ ] Osteoporosis

PRESENTING COMPLAINTS:

Mark the areas on this diagram where you feel the described sensations. Use the appropriate symbols, Mark all areas of radiation and include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing/ Sharp
_____	oooooo	xxxxxxx	*****	////////
_____	oooooo	xxxxxxx	*****	////////





On a scare of 0 to 10, 0 being no pain & 10 being the worse pain you've ever felt, please rate the following:

Neck pain:	0 1 2 3 4 5 6 7 8 9 10	Mid back pain:	0 1 2 3 4 5 6 7 8 9 10
Low back pain:	0 1 2 3 4 5 6 7 8 9 10	Other_____:	0 1 2 3 4 5 6 7 8 9 10

Printed Name Signature Date

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, Including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to reply on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____
Signature of Patient: _____
Name Printed of Guardian/Parental and Relationship to patient: _____
Guardian/Parental Signature: _____
Date: _____
Doctor of Chiropractic: _____
Signature of Doctor of Chiropractic: _____
Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment, Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

ELITE SPINE & SPORT

Release of Records

107 N. Cedar Ridge Drive, Suite 134

Duncanville, TX 75116

Phone: 972-298-2649 Fax: 972-692-5785

To: _____

_____

_____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including X-rays and photo-static copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward the reports and information requested to the above address:

_____

Signature

_____

Printed Name

_____

Date of Birth

_____

Social Security Number

_____

Date

ELITE SPINE & SPORT

I give consent to release medical information to the emergency contact listed. The duration of this notice is indefinite or until it is revoked in writing.

_____ _____

Emergency Contact Name Relationship

_____ _____

Phone Number Email Address

- **Completion of any form that *requires the Physician* to review or sign will be a $50.00 fee**
  - Please allow 7-10 business days to complete.
  - This includes FMLA and Disability forms.
- **No Show/Same day Cancellation fee is $25.00**
  - Appointment cancellation requires a 24-hour notice. This charge is generated through the computer and cannot be taken off.

I acknowledge that I have read, understand, and agree to be bound by the terms stated above.

_____ _____

Signature **Date**

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