

# PERSONAL CARE CHIROPRACTIC

## NEW PATIENT INFORMATION

A: FOR ALL PATIENTS

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt.# \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_ Sex: \_\_\_\_\_ E-Mail \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Spouse: \_\_\_\_\_ No. Of Children \_\_\_\_\_  
Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
DL#, State issued \_\_\_\_\_ Referred by: \_\_\_\_\_  
Name of Nearest Relative NOT living With you: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone( ) \_\_\_\_\_

B: FOR INSURANCE PATIENTS ONLY: ( NON INSURANCE PATIENTS CONTINUE AT "D").

Name of Insured: \_\_\_\_\_ Insured S.S.#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Patient's Relationship To Insured: (please circle) (S) Self (H) Husband (W) Wife (C) Child (O) Other \_\_\_\_\_  
Name of Insurance Program: (please circle) (IN) Major Medical (MD) Medicare (PI) Personal Injury (LI) Workman's Comp  
(O) Other: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City / State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insured Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City / State: \_\_\_\_\_ Zip: \_\_\_\_\_ Insured Group #: \_\_\_\_\_  
Insured Insurance I.D. #: \_\_\_\_\_  
Was Condition Related To: (please circle) Employment, Auto Accident, Other Injury: \_\_\_\_\_  
Date Condition/Accident Began \_\_\_\_/\_\_\_\_/\_\_\_\_ Was it Gradual? Yes No Loss of Work Time? Yes No  
No. of Days Off Work \_\_\_\_ Starting Date \_\_\_\_/\_\_\_\_/19\_\_\_\_ Was Laboratory Work Performed? Yes No  
Have You Ever Had Same or Similar Symptoms/Condition? Yes No.  
Do You Have Other Health Insurance? / Name of Insurance Company \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

C: FOR AUTO ACCIDENT AND WORKMAN'S COMP. PATIENTS ONLY.

Describe How Accident or Injury Occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have You Retained An Attorney? Yes No Name (if yes) \_\_\_\_\_  
Address: \_\_\_\_\_ City/ State : \_\_\_\_\_ Zip: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Name of Driver of Other Vehicle (if Any) \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_ Name of Adjuster \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ You Were (circle) Driver Passenger. Using Seat Belt? Yes No

D: FOR ALL PATIENTS.

What is Your Major Complaint? \_\_\_\_\_

Other Complaints? \_\_\_\_\_

What do you believe is Wrong With You? \_\_\_\_\_

Does Condition Interfere with: Work \_\_\_\_\_ Sleep \_\_\_\_\_ Daily Activity \_\_\_\_\_ Other \_\_\_\_\_

Is This Condition Getting Worse? Yes No Have You Done Anything To Treat This Condition Yourself? \_\_\_\_\_

Have You Seen Other Doctor For This Condition? Yes No Name of Doctor (if yes) \_\_\_\_\_

Diagnosis \_\_\_\_\_ Previous Chiropractic Care? Yes No

Name of Doctor (if yes) \_\_\_\_\_ Date of Last Adjustment \_\_\_\_\_

Past Surgery? Yes No. If Yes Explain: \_\_\_\_\_

Major Accidents or Falls? \_\_\_\_\_

Do you Smoke ? Yes No If Yes, How Many Packs a Day? \_\_\_\_\_

E: PRESENT HEALTH HISTORY-- FOR ALL PATIENTS.

Check any of the following you have or have had in the past year. O - Occasional F - Frequent C - Constant

**MUSCULO-SKELETAL SYSTEM**

- |     |     |     |                             |
|-----|-----|-----|-----------------------------|
| O   | F   | C   |                             |
| ___ | ___ | ___ | Muscle Twitching /cramps    |
| ___ | ___ | ___ | Arthritis                   |
| ___ | ___ | ___ | Bursitis                    |
| ___ | ___ | ___ | Low Back Pain               |
| ___ | ___ | ___ | Neck Pain                   |
| ___ | ___ | ___ | Pain Between Shoulders      |
| ___ | ___ | ___ | Joint Pains/ Stiffness      |
| ___ | ___ | ___ | Walking Problems            |
| ___ | ___ | ___ | Scoliosis(spinal curvature) |
| ___ | ___ | ___ | TMJ                         |
| ___ | ___ | ___ | Muscle Weakness             |
| ___ | ___ | ___ | Shoulder Pain L R           |
| ___ | ___ | ___ | Arm Pain L R                |
| ___ | ___ | ___ | Leg Pain                    |
|     | L   | R   |                             |
| ___ | ___ | ___ | Knee Pain L R               |
| ___ | ___ | ___ | Hip Pain L R                |
| ___ | ___ | ___ | Feet/Ankle Pain L R         |
| ___ | ___ | ___ | Tennis Elbow L R            |

**CARDIOVASCULAR SYSTEM**

- |     |     |     |                         |
|-----|-----|-----|-------------------------|
| O   | F   | C   |                         |
| ___ | ___ | ___ | Chest Pain              |
| ___ | ___ | ___ | Blood Pressure Problems |
| ___ | ___ | ___ | Irregular Heart Beat    |
| ___ | ___ | ___ | Diabetes                |

**NERVOUS SYSTEM**

- |     |     |      |                         |
|-----|-----|------|-------------------------|
| O   | F   | C    |                         |
| ___ | ___ | ___  | Dizziness               |
| ___ | ___ | ___  | Forgetfulness           |
| ___ | ___ | ___  | Fainting                |
| ___ | ___ | ___  | Convulsions             |
| ___ | ___ | ___  | Confusion/Depression    |
| ___ | ___ | ___  | Cold/Tingling Arms/Legs |
| ___ | ___ | ___  | Pinched Nerve           |
| ___ | ___ | ___  | Numbness                |
|     |     | Area | 1. _____                |
|     |     |      | 2. _____                |
|     |     |      | 3. _____                |

**GASTRO-INTESTINAL SYSTEM**

- |     |     |     |              |
|-----|-----|-----|--------------|
| O   | F   | C   |              |
| ___ | ___ | ___ | Belching/Gas |
| ___ | ___ | ___ | Constipation |
| ___ | ___ | ___ | Diarrhea     |
| ___ | ___ | ___ | Nausea       |
| ___ | ___ | ___ | Stomach Pain |

**RESPIRATORY SYSTEM**

- |     |     |     |                      |
|-----|-----|-----|----------------------|
| O   | F   | C   |                      |
| ___ | ___ | ___ | Difficulty Breathing |

**EYES/EARS/NOSE/THROAT**

- |     |     |     |                 |
|-----|-----|-----|-----------------|
| O   | F   | C   |                 |
| ___ | ___ | ___ | Asthma          |
| ___ | ___ | ___ | Ear Ringing     |
| ___ | ___ | ___ | Blurred Vision  |
| ___ | ___ | ___ | Double Vision   |
| ___ | ___ | ___ | Eye Pain        |
| ___ | ___ | ___ | Sinus Infection |

**GENERAL**

- |     |     |     |               |
|-----|-----|-----|---------------|
| O   | F   | C   |               |
| ___ | ___ | ___ | Allergies     |
| ___ | ___ | ___ | Loss of Sleep |
| ___ | ___ | ___ | Headache      |
| ___ | ___ | ___ | Stress        |

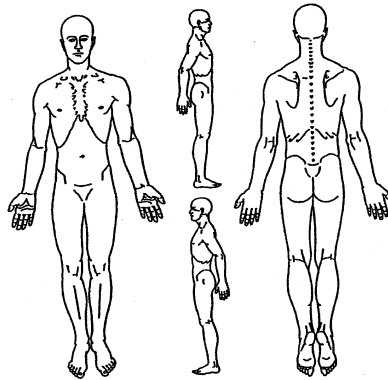
**WOMEN ONLY**

- |     |     |     |                         |
|-----|-----|-----|-------------------------|
| O   | F   | C   |                         |
| ___ | ___ | ___ | Menstrual Irregularity  |
| ___ | ___ | ___ | Menstrual Cramping      |
| ___ | ___ | ___ | PMS(Pre-menstrual synd) |

Are You Pregnant?

\_\_\_ yes \_\_\_ No \_\_\_ Maybe

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT AND TYPE THE DISCOMFORT ACCORDING TO THE FOLLOWING CODES: BE AS SPECIFIC AS POSSIBLE.



- |    |                    |    |            |    |              |    |               |    |          |
|----|--------------------|----|------------|----|--------------|----|---------------|----|----------|
| 1. | Dull Ache          | 2. | Sharp Pain | 3. | Burning Pain | 4. | Stabbing Pain | 5. | Numbness |
| 6. | Weakness of Muscle |    |            |    |              |    |               |    |          |

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his recommendation is an incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- |                                      |  |  |   |
|--------------------------------------|--|--|---|
| <input type="checkbox"/> Relief Care | <input type="checkbox"/> Corrective Care | <input type="checkbox"/> Preventative Care | <input type="checkbox"/> Check here if you want the doctor to select the type of care appropriate for your condition. |
|--------------------------------------|--|--|---|

# PERSONAL CARE CHIROPRACTIC

## INFORMED CONSENT

Physicians, Chiropractors, Osteopaths and physical therapists using manual manipulation are required to advise their patients of the following:

1. With neck problems there have been rare incidents of injury to the vertebral artery during the course of treatment. These have caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are approximately 2 in 1 million treatments.
2. With neck or back problems there have been rare incidents of rib separation or fracture, disc disease and more common , pain, bruising, swelling or aggravation of symptoms.

### APPROPRIATE TESTS WILL BE PERFORMED ON YOU TO MINIMIZE YOUR RISK

**I hereby consent to the chiropractic treatment as indicated , needed and explained to me . If during the course of treatment unforeseen conditions are discovered or unusual conditions develop, I further consent to such additional diagnostic measures and treatment as may be indicated by sound and prudent chiropractic practice which may require additional X-ray, chiropractic orthopedic neurological and or laboratory testing or consulting with another doctor.**

**No guarantee or warranty has been made to me that results will be to my complete satisfaction. Having read this form, I understand and consent to treatment.**

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**PERSONAL CARE CHIROPRACTIC**

**CONSENT TO X-RAY , CHIROPRACTIC DIAGNOSTIC PROCEDURE AND TREATMENT**

I \_\_\_\_\_ CONSENT TO THE PERFORMANCE OF X-RAY STUDIES,  
PHYSICAL EXAM AND CHIROPRACTIC TREATMENT ON ME AT PERSONAL CARE CHIROPRACTIC.

\_\_\_\_\_  
Patient's name and signature

\_\_\_\_\_  
Date

**FOR WOMEN ONLY**

**PREGNANCY RELEASE**

Date of last menstrual period (LMP): \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR AND GROUP ACCIDENT  
AND HEALTH INSURANCE**

RE:

Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim/Group: \_\_\_\_\_

SS#/ID#: \_\_\_\_\_

I hereby instruct and direct the \_\_\_\_\_ insurance company to pay by check made out and mailed directly to:

PERSONAL CARE CHIROPRACTIC  
3900 West 15th St. Suite #506  
Plano , TX. 75075  
Tel (972) 985 1432, Fax (972) 985 8779

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

**A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**

I also authorize the release of any information pertinent to my case to any insurance company, adjuster ,or attorney involved in this case.

Signature of policy holder \_\_\_\_\_ Date \_\_\_\_\_

Signature of claimant(if other than policy holder) \_\_\_\_\_

Witness \_\_\_\_\_