Cross Timbers Chiropractic

Confidential Patient History

Please PRINT clearly.

Name: (Last, First, MI) _____ **Preferred Name**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Mobile**: _____ **Work**: _____

Email: _____ **Gender**: M / F **Marital Status**: Married / Single / Other

Date of Birth: _____ **Occupation**: _____ **Employer**: _____

Spouse/Significant Other: _____ **Children and Ages**: _____

Are you: Military Veteran / Active Duty Service Member / Reservist / National Guard / ROTC

Referred by (*name*): _____

☐ **Family** ☐ **Friend** ☐ **Co-Worker** ☐ **Doctor** ☐ **Other**: _____

- CMS requires Providers to report both race and ethnicity -

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer **Preferred Language**: _____

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ **Preferred Contact Number**: _____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____ **Doctor's Phone**: _____

FINANCIAL INFORMATION -- Please allow us to photocopy your Insurance card

Self Pay (Cash) / Insurance / Personal Injury/Auto / Other (please explain): _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE**: _____

Policy Holder: _____ **Policy Holder**: _____

Relation to Insured: Self / Spouse / Parent / Child / Other **Relation to Insured**: Self / Spouse / Parent / Child / Other

Patient Name: _____

CURRENT CONDITION INFORMATION

PLEASE ANSWER ALL QUESTIONS

Major Complaint: _____

When did this Episode start (date): _____ **What event caused it**: _____

If this is not the first time, how long has this been a recurring problem? _____

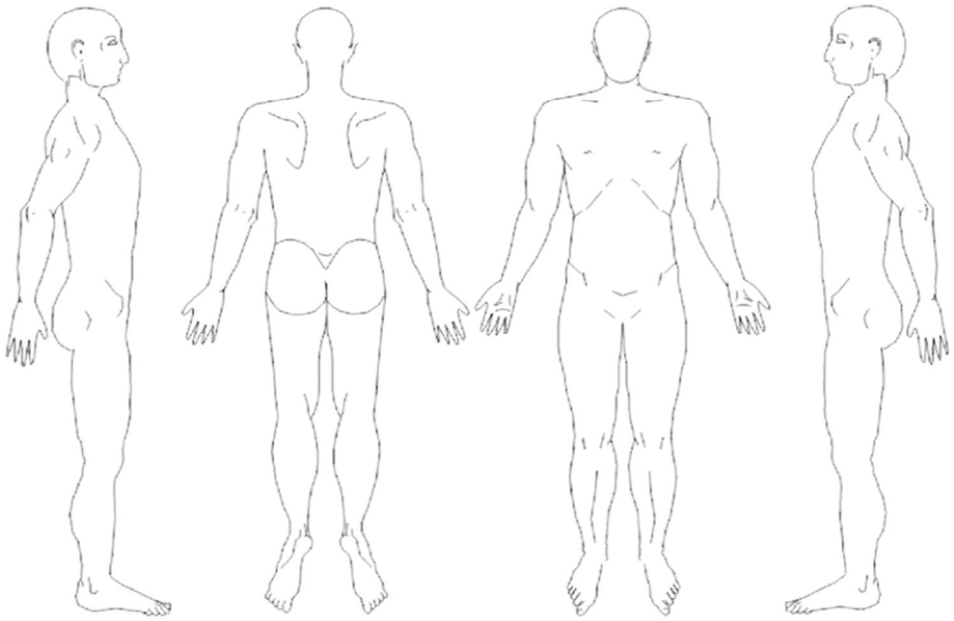
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderate-Severe (6-8) Severe (8-10)

The complaint is: Constant / Comes and Goes

Is the complaint: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Pins and Needles / Other: _____

Does it Radiate/Shoot to any areas of your body? No / Yes **If YES, where**: _____

DRAW AREAS OF COMPLAINTS:



What makes it better? Ice / Heat / Rest / Movement / Stretching / OTC Meds / RX Meds / Chiropractic

What makes it worse? Sit / Stand / Walk / Lying Down / Sleep / Movement

Who else have you seen for this? No One / DC / MD / PT / Massage / ER / Other: _____

Where?: _____

Diagnostic Tests: None / X-Rays / MRI / CT / Other: _____ **When and Where**: _____

Any other complaints: _____

Patient Name: _____

Does anyone in your immediate family have a history of (circle condition): ☐ None

Heart Disease If yes, who _____ **Stroke** If yes, who _____

Cancer If yes, who _____ Type _____ **Other relevant family history**: _____

PAST HEALTH HISTORY: (List even if it was 20 years ago...)

Injuries, Traumas, or Hospitalizations: ☐None Yes: _____

Current Medications: If you brought a list, we can make a copy ☐None Yes: _____

Allergies to Medications: List and reactions ☐None

:_____

Vitamins and Supplements: List all and frequency ☐None

:_____

Are you currently experiencing any of these symptoms? (Check all that apply)

General:
- ☐ Recent Unintentional Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Broken Bones
- ☐ Muscle Spasms/Cramps
- ☐ *None in this category*

Neurological:
- ☐ Numbness or Tingling Sensations
- ☐ Loss of Feeling
- ☐ Dizziness of Light Headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions of Seizures
- ☐ Have you ever had a head injury?
- ☐ Had an auto accident? Year? _____
- ☐ *None in this category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ *None in this category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat Changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ *None in this category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Tobacco Use
- ☐ *None in this category*

Eyes and Vision:
- ☐ Wear Contacts / Glasses
- ☐ Blurred or Double Vision
- ☐ Eye Disease or Injury
- ☐ *None in this category*

Ears, Nose, and Throat:
- ☐ Swollen Glands in Neck
- ☐ Ringing in Ears
- ☐ Ear-Ache / Ringing / Drainage
- ☐ Sinus / Allergy Problems
- ☐ *None in this category*

Mind / Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ *None in this category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Cold Extremities
- ☐ Heat or Cold Intolerance
- ☐ Immune System Disorder
- ☐ *None in this category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Non-healing Sores
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ *None in this category*

Genitourinary:
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in Force / Strain w/Urination
- ☐ Frequent Urination
- ☐ Urinary Leakage or Bed Wetting
- ☐ Blood in Urine
- ☐ *None in this category*

Women Only:

Are you pregnant?
- ☐ Yes - Due Date: _____
- ☐ No - Last Menstrual Period: _____
- ☐ Painful or Irregular Periods
- ☐ Urine Leakage with Coughing or Sneezing
- ☐ Urine Leakage with Laughing or Lifting
- ☐ *None in this category*

Pregnancies with Outcome & Date:

_____

_____

Other conditions not listed: _____

Is there anything else you would like the doctor to know? _____

Patient Name: _____

Informed Consent to Treatment

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize and release the doctor and any individual he/she may designate as his assistant to administer treatment, physical examination, x-ray studies, chiropractic care, or any clinical services that he deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

Patient Signature: _____ Date: _____

Consent to Email/ Text Usage

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at the email or text address from the practice.

Patient Signature: _____ Date: _____

Health Insurance Portability & Accountability Act (HIPAA) Consent

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice. I understand that a clinical summary report (CSR) is created after each visit for the purpose of electronic health records (EHR) and is available for my review. At this time, I am asking Cross Timbers Chiropractic to save these electronically for me and not print them out after each visit. I understand, upon request, that these reports are available to be printed or emailed to me for review.

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible, co-insurance, and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier.
If your Insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Patient Signature: _____ Date: _____