Patient Contact Information

Title: Last name: Middle: First: Nickname:

Spouse's Name: Do you have children? ┐ Yes ┐ No Ages: _____ _____ _____ _____ _____

Address: City: State: Zip:

Primary Phone: Mobile Phone:

Sex : Male / Female Date of Birth:

Home email: Work email:

Employment (circle one) Occupation: Employer:

Employed Student P/T Student F/T
Other Retired Self Employed

Marital status (circle one) Referred by: Other family members seen here:

Single / Mar

CONFIDENTIALITY QUESTIONNAIRE

In Order to comply with HIPPA guidelines (effective 4-12-03), it is necessary for you to complete the following information:

Who may we inform about your general medical condition, diagnosis, test results or treatment plan? This includes, but is not limited to general questions about your condition.

Name:	Relation:	Phone:

May we leave confidential (billing/medical condition/missed appointment) messages on:

Your Primary Phone? YES NO

Text Appointment Reminders? YES NO

Your Mobile Phone? YES NO

Your Work email? YES NO

Your Home email? YES NO

Would you like to receive updates and messages/alerts via e-mail? YES NO

Would you like us to send reports and updates to your Referring Physician? YES NO

If Yes: Name:_____

I understand that this consent will remain in effect until revoked IN WRITING by myself, or my legal guardian/parent.

_____ _____ _____

Signature **Date** **Relationship**

**********PLEASE NOTE**********

If you fail to notify our office **in writing** that you would like to have an individual removed from any of the above, that person **will** be able to obtain information about you from our office.

Medical History for (print) :

Name of your family Doctor/Primary Care Physician:

What city and state?

Date of last Visit: / / / Date of last exam: / / /

Past Surgeries (year):

Current Condition

The reason for this visit:

Have you been treated by a Medical Physician <u>for this condition</u>? ¬ **Yes** ¬ **No**
If so, who, when & where?

Have you ever been treated by a Chiropractor before? ¬ Yes ¬ No Was it for the current condition? ¬ Yes ¬ No
If so, who, when & where? .

Present/Past Illness /Conditions (ROS):

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Current Medications:

Family History of Illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitis

Other:

Type of Cancer:

Patient Medical History, Continued

Social History:

Alcohol Consumption? ┐ Yes ┐ No ___drinks/week

Coffee Consumption? ┐ Yes ┐ No ___drinks/week

Soda pop Consumption? ┐ Yes ┐ No ___drinks/week

Water Consumption: ____drinks/week

Sleep Amount? ____hours/night

Pain Relievers? ┐ Yes ┐ No ____#per day

Recreational Drug Use? ┐ Yes ┐ No

Healthy Eating Rank? (0-poor, 10 excellent)

0 1 2 3 4 5 6 7 8 9 10 N/A

Exercise Frequency: ____hours/day

Physical Stress level? 0(none)-10(extreme)

0 1 2 3 4 5 6 7 8 9 10 N/A

Emotional Stress Level? 0(none)-10(extreme)

0 1 2 3 4 5 6 7 8 9 10 N/A

Major Stressors:

Things to Improve:

Other Health Goals:

Smoking History

Currently Smoke? ┐ Yes ┐ No

Years Smoked? _____years

Packs Per Day? _____

Smoked in Past: ┐ Yes ┐ No

Level of Interest in Quitting 0 (none)- 10 (extreme)

0 1 2 3 4 5 6 7 8 9 10 N/A

Comments on Smoking?

Comments:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

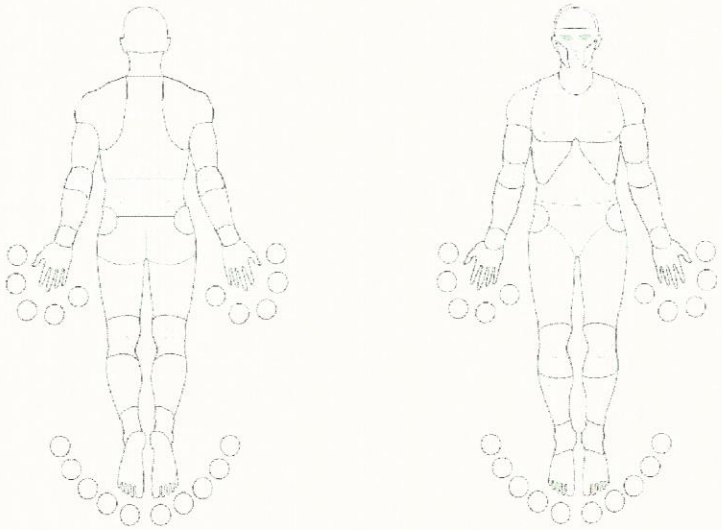
Patient Name (Printed): _____

Patient Signature: _____ Date: _____

Current Complaints

Patient's Name: _____ Date: _____

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below. If you have more than one region of complaints, use additional sheets.



Office Use Only	
Hgt: "	Respiration: bpm
Wgt lbs	BP____/____ mm Hg
BMI	Temperature F
Pulse: bpm	Right / Left Handed
Regional Assessment	
NECK	BACK
LEFS	DASH

Area(s) of Complaint				
Pain / Symptom Intensity:	**0 (None) 1 2 3 4 5 6 7 8 9 10 (Excruciating) N/A**			
Mechanism Of Injury:				
Onset, When and how did the condition begin?				
***Frequency* (How Often?)**	Infrequent < 25%	Occasional 25%-50%	Frequent 50% - 75%	*Constant > 75%*
Duration: How long?	____ days, weeks, months, years over the past ____ days, weeks, months, year(s)			
When does it seem to be at its worse? (Timing)				
☐ Morning ☐ Midday ☐ End of Day ☐ Throughout the day ☐ Night with Pain During / After - ☐ Light ☐ Moderate ☐ Strenuous - Activities				
Would you describe the pain as radiating/shooting?, If so where?				
☐ Yes ☐ No				
This symptoms are described as: (Quality)				

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	
What makes it worse (Aggravating Factors)?					
Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking Up	Looking Down	Movement	Rest	Lying Supine	Driving
Typing	Scooping	House Chores	Exercise	Lying Prone	Stair Stepping
What makes it better? (Relieving Factors)					

Sitting	Standing	Lying	Knees bent up	Support
No Movement	Movement	Heat	Ice	Analgesic Topical
Ibuprophen	Medication	Rest	Stretching/Exercise	Adjustments

Comments: _____

_____

_____

_____

Patient's Signature

True Balance Chiropractic & Physical Therapy
2771 East Broad St #211
Mansfield, TX 76063
ph: 682-518-6263

ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that True Balance Chiropractic & Physical Therapy"Notice of Privacy Practices" has been provided to me.

I understand I have a right to review True Balance Notice of Privacy Practices prior to signing this document. True Balance's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of True Balance. The Notice of Privacy Practices for True Balance is also provided on request at the front desk of this practice and on True Balance's website at www.truebalancerehab.com. This Notice of Privacy Practices also describes my rights and True Balance's duties with respect to my protected health information.

True Balance reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing True Balance's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Consent to Treat

Chiropractic examination (history, examination, and x-rays) and therapeutic procedures (including but not limited to spinal and/or extremity adjustments, heat/cold application, mechanical traction, acupuncture, manual muscle therapy, electrical muscle stimulation, therapeutic ultrasound, and therapeutic exercises) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of True Balance, to inform the patients about them. Additional diagnostics such as advanced imaging, laboratory tests and/or outside medical referral may also be ordered as needed.

Complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, and temporary worsening of symptoms. More serious complications such as fractures and stroke are extremely rare. Additional information on side effects and complications can be explained by your treating doctor upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result. It is understood that this authorization is given in advance of *any specific diagnosis or treatment being required.*

I consent to the provisions of care. I understand that this care may include treatment, special tests, exams, evaluations, and rehabilitation. I understand that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist in providing care. This may include any staff members or interns of True Balance.

This authorization shall remain effective unless revoked in writing by the undersigned.

True Balance Chiropractic & Physical Therapy
2771 East Broad St #211
Mansfield, TX 76063
ph: 682-518-6263

Consent to Acupuncture Treatment

I consent to being treated with acupuncture needle procedures as part of the chiropractic care rendered to me by True Balance. I have been informed of the potential risks of the procedures, which are similar to those of an injection procedure or needle immunization procedure.

***I understand that only sterile packaged single use needles will be used and that standard clean needle technique* will be followed. The procedures have been explained to me and I understand them to my satisfaction.** ☐

Consent to Treatment (Minor)

I hereby request and authorize True Balance to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office. ☐

X-Ray Consent

I consent to those diagnostic x-ray procedure(s) my referring doctor may consider necessary in the course of my health case. I understand the nature and purposes of these procedure(s) and the risks involved, as well as the consequences of not consenting to the procedures.

Female Patient Only
Some X-Ray and CT examinations may expose the uterus. In order to avoid any unnecessary fetal exposure in the event of pregnancy, the 10 days immediately following the onset of the menstrual period are generally considered the safest for x-ray examinations.

Onset of last menstrual period		Date	Today's Date
I am post menopausal	Yes	No	Don't Know
I am Pregnant	Yes	No	Don't Know
I have had a hysterectomy	Yes	No	Don't Know
I use an IUD	Yes	No	Don't Know

I recognize that if I am pregnant and have radiation, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my doctor feels the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed at this time.

Patient/Guardian: _____ Date: _____

Witness: _____ Relationship: _____