



CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Patient Information

Date: _____

Patient Name: _____ Age: _____ SSN: _____

Email address: _____ Sex: Male Female

Date of Birth: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation (job title): _____ Employer: _____

Employer Address: _____ Work Phone: _____

Which telephone number would you like us to use for appointment reminders? Home / Work / Cell

Whom may we thank for referring you? _____

Insurance Information

Who is responsible for this account? _____

Relationship to patient: _____

Suscriber's name: _____

Suscriber's birth date: _____ SSN: _____

Assignment of Benefits

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ (name of insurance carrier) and assign directly to _____ (name of doctor) all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____



DFW's Premier Sports Chiropractic Facility.

Reason for Visit

Describe what hurts, or your reason for this visit:

Are you here because of an accident? _____ What type? _____

When did your symptoms start? _____ How did your symptoms begin? _____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (Circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Are your symptoms? (Circle one) Getting better Staying the same Getting worse

How do your symptoms interfere with your work or normal activities? _____

Have you experienced these symptoms in the past? (If Yes, when) _____

What aggravates your condition? _____

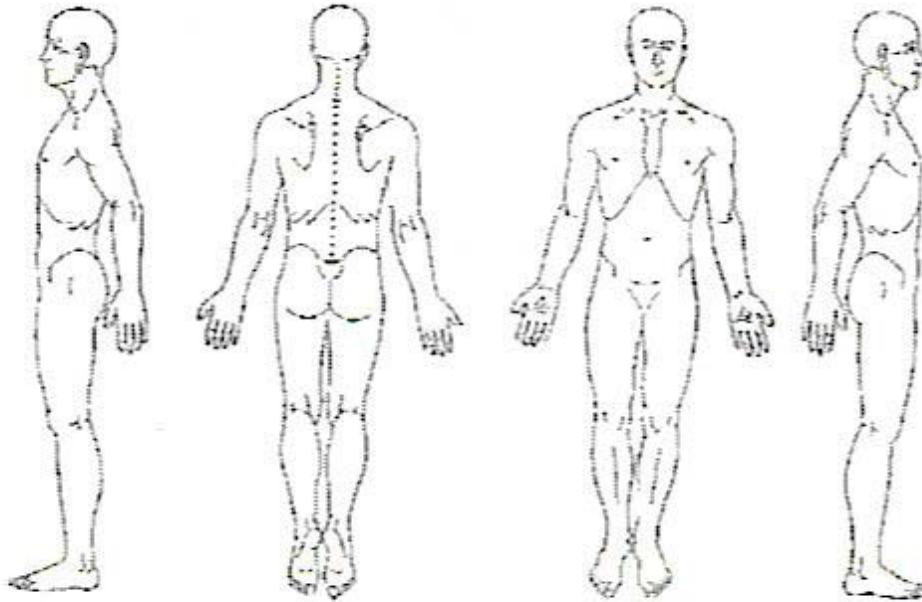
What makes your pain better? _____

Additional comments for your doctor: _____

Description of Condition

Mark any area(s) of discomfort with the following key:

A =Ache **N** =Numbness **B** = Burning **T** = Tingling **S** = Stiffness **O** = Other



Left

Back

Front

Right

On a scale of one to ten, how intense are your symptoms? No Pain ①②③④⑤⑥⑦⑧⑨⑩ Unbearable Pain

Lifestyle History

Do you exercise? Yes No Hours per week _____ What activity(s)? _____

Do you wear? Heal lifts Arch supports Prescription Orthotics

Are you dieting? Yes No Since: _____

Do you smoke? Yes No _____ packs per day. How long have you been smoking? _____

Do you drink alcoholic beverages? Yes No _____ drinks per week.

For women: Are you pregnant or nursing? Yes No

If pregnant, How many weeks? _____ Date of last menstrual period: _____

Symptom Checklist

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		<u>Musculoskeletal</u>			<u>Cardiovascular</u>			<u>Genitourinary</u>
<input type="radio"/>	<input type="radio"/>	Neck Pain	<input type="radio"/>	<input type="radio"/>	Angina/Chest Pain	<input type="radio"/>	<input type="radio"/>	Bladder Infection
<input type="radio"/>	<input type="radio"/>	Upper/Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>	Frequent Urination
<input type="radio"/>	<input type="radio"/>	Low Back Pain	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Shoulder Pain	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Kidney Stones
<input type="radio"/>	<input type="radio"/>	Elbow/Upper Arm Pain	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Wrist/Hand Pain	<input type="radio"/>	<input type="radio"/>	Blood Clots			<u>Ear/Nose/Throat</u>
<input type="radio"/>	<input type="radio"/>	Hip/Upper Leg Pain	<input type="radio"/>	<input type="radio"/>	Vascular Disease	<input type="radio"/>	<input type="radio"/>	Allergies/Asthma
<input type="radio"/>	<input type="radio"/>	Knee/Lower Leg Pain			<u>Metabolic</u>	<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis
<input type="radio"/>	<input type="radio"/>	Ankle/Foot Pain	<input type="radio"/>	<input type="radio"/>	Abnormal Weight Gain/Loss			<u>Systemic Conditions</u>
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Low Bone Density	<input type="radio"/>	<input type="radio"/>	Cancer/Tumors
<input type="radio"/>	<input type="radio"/>	Joint Swelling/Stiffness	<input type="radio"/>	<input type="radio"/>	Excessive Thirst	<input type="radio"/>	<input type="radio"/>	Chronic Fatigue
<input type="radio"/>	<input type="radio"/>	Joint Dislocation	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Systemic Lupus
<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	Thyroid Problems	<input type="radio"/>	<input type="radio"/>	Spinal Infection
<input type="radio"/>	<input type="radio"/>	Jaw Pain			<u>Gastrointestinal</u>	<input type="radio"/>	<input type="radio"/>	HIV/AIDS
		<u>Neurological</u>	<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Hepatitis
<input type="radio"/>	<input type="radio"/>	Concussion	<input type="radio"/>	<input type="radio"/>	Liver/Gallbladder Disorder	<input type="radio"/>	<input type="radio"/>	Anemia
<input type="radio"/>	<input type="radio"/>	Memory Loss	<input type="radio"/>	<input type="radio"/>	Ulcer			<u>Psychological</u>
<input type="radio"/>	<input type="radio"/>	Epilepsy			<u>Dermatological</u>	<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Excessive Weakness	<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Anxiety
<input type="radio"/>	<input type="radio"/>	Loss of Sensation/Bowel/Bladder Function	<input type="radio"/>	<input type="radio"/>	Psoriasis	<input type="radio"/>	<input type="radio"/>	Alcohol/Drug Abuse
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Acne	<input type="radio"/>	<input type="radio"/>	Mood Swings

Medication & Supplements

List all prescription, over-the-counter medications and other supplements you take as well as the associated condition:

Personal Health History

List any Surgeries or Hospitalizations you have had, including the month and year for each:

List any Auto Collisions you have had, including the month and year for each:

List any Job, Sports, or Other Injuries you have had, including the month and year for each:

List any Allergies that you are aware of: _____

Family Health History

List all Major Diseases (such as Bone/Joint Diseases, Cancer, Diabetes, Heart Problems, Stroke, etc.) in your family and the family member's relation to you

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? Yes No

Have you seen a Chiropractor before? Yes No

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: _____



Patient Consent for use and Disclosure of Protected Health Information

Medical groups must provide patients with a notice describing how protected health information may be used and disclosed. This information includes patient's rights and medical group's duties.

I hereby give consent for **Spring Valley Chiropractic** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The *Notice of Privacy Practices* provided by **Spring Valley Chiropractic** describes such uses and disclosures more completely.)

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. **Spring Valley Chiropractic** reserves the right to revise the *Notice of Privacy Practices* at any time. A revised *Notice of Privacy Practices* may be obtained behind the front desk at our office at 5323 Spring Valley Rd., Ste 100, Dallas, Texas 75254.

With this consent, **Spring Valley Chiropractic** may call my home or other alternative location and leave a message on voice mail or by person, mail correspondence through USPS or similar means or electronic mail (email) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including diagnostic testing results, among others.

_____ I acknowledge that I have been informed that I can request a copy of the Notice of Privacy Practices from **Spring Valley Chiropractic** and consent to allow them to use and disclose my PHI to carry out TPO.

_____ I have received a copy of Notice of Privacy Practices from **Spring Valley Chiropractic**.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Spring Valley Chiropractic** may decline to provide treatment to me.

Signed By: _____
(Signature of patient or Legal Guardian) (Date) (Relationship to patient if other than self)

(Print Patient Name) (Print name of Legal Guardian if applicable)



APPOINTMENT CANCELLATION POLICY

In an effort to reduce patient waiting times and guarantee your reserved appointment time, we recommend scheduling your appointments in advance. Since our staff is usually booked a week in advance, **we require a one-day (24 hour) notice to cancel or reschedule appointments.** Patients that do not show for scheduled appointment or call at the last minute will be in violation of this policy and will be assessed a \$20 cancellation fee.

Patient Signature: _____ Date: _____

Please note that your insurance company will not pay for missed appointments. By signing this document you give us the right to bill your credit card for the missed appointment. If you do not have a credit card on file, you will be billed directly.



Disclosure & Consent to Chiropractic Treatment

Doctors of chiropractic who utilize spinal manipulation and other manual therapy techniques are required to advise patients about the potential risks associated with such procedures. We are also required to inform you of other treatment options, should you inquire about them.

- A. While rare, some patients may experience short-term aggravation of symptoms, fractures, or muscle and ligament strains/sprains as a result of spinal manipulation.
- B. There have been reported cases of stroke associated with manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasions result in injuries including paralysis. The possibility of such injuries resulting from upper cervical adjustments is extremely rare.
- C. There are rare reported cases of disc injuries following spinal manipulation although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to you overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical procedures, medications, and treatments give for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature of my condition and the various treatment modalities to be used in my treatment. I also acknowledge that I have been informed of the possible side effects of such treatment, as well as other possible treatment options.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to my present and all my future visits.

Dated this _____ day of _____, 20____.

Patient Signature (or legal guardian)

Doctor's Signature

Print Patient's Name

Print Doctor's Name