Houston
CHIROCARE
& REHAB

PATIENT INFORMATION

Name_____ Date of Birth_____ Social Security #__XXX-XX-_____

Address_____Apt. # _____ City_____ State _____ Zip _____

Home Ph# _____Cell Ph#_____ Driver's License # _____

E-mail address: _____

Race: ___Afro-American ___Am-Indian ___ American ___Asian ___Black ___Caucasian ___Hispanic ___Other

Marital Status: S M D W No. of Children: ____ Gender: F M

Emergency Contact: Name: _____ Relation ship: _____

Phone No. _____

How did you hear of us? __ **Internet** __**Billboard** __**Phone Book** __**Friend/Patient**_____ **Other**_____

WORK INFORMATION

Name of Company_____

Address _____City _____State _____Zip _____

Phone #_____ Fax # _____ Contact Person_____

INSURANCE INFORMATION

Your Health Insurance Co._____ Phone # _____

Member Name _____Member ID _____Group #_____

Date of Onset _____ Have you been treated for this condition? YES/NO Doctor's name_____

Doctor's Location/Phone number _____

Briefly describe your condition_____

_____

_____

PATIENT'S SIGNATURE_____ **DATE**_____

Check any of the following symptoms you have noticed:

C: Current **P: Past**

Heart & Vascular	**C**	**P**	**Mental Health**	**C**	**P**
Heart Disease			Irritability or Depression		
Dizziness			Anxiety		
Difficulty Breathing			Memory Loss		
Confusion			Difficulty Sleeping		
Shortness of Breath			Drug/ Alcohol Abuse		
Fatigue			Headaches		
Angina			Fainting		
High Blood Pressure					
Nausea			**Neuromusculoskeletal**	**C**	**P**
Vomiting			Neck Pain or Stiffness		
Thrombophlebitis			Shoulder Pain		
Cold Sweats			Arm/Hand Numbness/Tingling		
Light Headedness			Arm/Hand Fatigue/Weakness		
Severe Sudden Headaches			Leg/Foot Numbness/Tingling		
Sudden Weakness/ Numbness of Face, Arm, Leg, Esp. One Side			Leg/Foot Fatigue/Weakness		
Deep Leg Pain when Walking			Abdominal Pain		
			Mid Back Pain		
Systemic Conditions	**C**	**P**	Low Back Pain		
Pneumonia			Joint Pain Swelling/ Stiffness		
Emphysema			Pain with Exercise (Activity, Climbing, Stairs, etc)		
Chest Pain or Cough			Paralysis		
Gall Blander Disease			Muscle Weakness		
Kidney Stones					
Liver Disease			**Other**	**C**	**P**
Blood in Urine or Stool			Seizures		
Difficulty or Pain w/ Urination			Numbness/Tingling		
Fatigue or Loss of Energy			Jaw Pain, Clicking or Locking		
			Lumps (where?)		
Ear, Nose, Throat, Eyes, Skin	**C**	**P**	Diarrhea or Constipation		
Visual or Hearing Disturbance			Loose of Appetite		
Rashes (Face, Body, Limps)			Abnormal Menstrual Periods		
Pain or Difficulty Swallowing					
Sensitive to Light or Sound					

INITIALS: _____

Houston CHIROCARE & REHAB

MEDICAL HISTORY

Have you ever been hospitalized due to an accident or an illness? YES / NO If yes, please explain._____

_____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):_____

_____

Have you recently notice any changes in you bodily function? i.e., intestinal/urinary functions, loss of weight, frequent dizziness, fatigue, nausea, vomiting, etc. YES / NO If yes, please explain: _____

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries before (include dates): _____

List any on the job injuries (include dates): _____

Have you had any broken bones? YES / NO if yes, please list and give dates: _____

Have you ever had done: ____MRI ____ CT ____X-Ray Associated with this injury? _____

List all current over-the-counter and prescription medication used (include reason used): _____

_____

List any heath conditions that run in your family (cancer, diabetes, heart disease, etc.):_____

_____

Have you been under physician's care in the past year? YES / NO (Reason) _____

_____

When was your last physical examination? _____

_____

Have you ever been under chiropractic care? YES / NO (DESCRIPTION/REASON) _____

_____

If **female**, is there a possibility that you are pregnant? YES / NO

Are there any other additional health concerns or questions you have?

_____

_____

_____

INITIALS: _____

Houston ChiroCare & Rehab

13630 Veterans Memorial Dr, Ste G. Houston, TX 77014

1. CONSENT TO EXAMINATION & DIAGNOSTIC PROCEDURES

I, _____, do hereby authorize HOUSTON CHIROCARE & REHAB, doctors, associates, or assistants to perform upon my examination and diagnostic procedures (not limit to but including x-ray examination) arising from any current or presently unforeseen conditions, which HOUSTON CHIROCARE & REHAB, doctors, associates, or assistants may consider necessary or advisable in the course of my health care.

I understand and agree that HOUSTON CHIROCARE & REHAB, its doctors, associates, or assistants have the right to refuse to accept me as a patient any time before treatment begins. The taking of a history and conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctors and associates of HOUSTON CHIROCARE & REHAB can determine to accept me as a patient.

PATIENT'S NAME _____

PATIENT SIGNATURE _____ DATE _____

SIGNATURE OF PATIENT'S
REPRESENTATIVE _____ DATE_____

SIGNATURE OF
WITNESS _____ DATE _____

2. ASSIGNMENT OF BENEFITS

I irrevocably assign to **Houston ChiroCare & Rehab** all my rights and benefits under any insurance contracts for payment for services rendered to me by **Houston ChiroCare & Rehab**. I irrevocably authorize all information regarding my benefits under any insurance policy relating to claims by **Houston ChiroCare & Rehab** to be released to **Houston ChiroCare & Rehab**. I irrevocably authorize **Houston ChiroCare & Rehab** to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to **Houston ChiroCare & Rehab**. I irrevocably authorize **Houston ChiroCare & Rehab** to act in my behalf and report my suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

I authorize the release of any medical or any other information necessary to process any claims for services rendered. I authorize the payment of benefits for services rendered to **Houston ChiroCare & Rehab**. I authorize a copy of this consent and authorization to be used in all of my insurance submissions. I authorize **Houston ChiroCare & Rehab** to endorse any checks made payable to me and/or **Houston ChiroCare & Rehab** for services rendered.

DO NOT SIGN UNTIL YOU READ AND UNDERSTAND THE ABOVE

_____	_____	_____
Name of Doctor (Print)	Doctor's Signature	Date
_____	_____	_____
Name of Patient (Print)	Patient's Signature	Date
	_____	_____
	Signature of Patient's Representative (If minor or physically incapacitated)	Date

Houston
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& REHAB

PATIENT AGREEMENT

Houston ChiroCare & Rehab specialize in the treatment of the spine and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, as with any chiropractic and/or physical medicine services there are risks associated with the services we provide.
As your healthcare provider, we feel that it is crucial that you understand these risks. By informing you of these risks we are striving to more actively involve you in our case as well as further assist you in making well-informed decisions regarding your treatment options.

PASSIVE MODALITIES
Passive modalities consist of the following treatments: heat/cold agent, ultrasound, electrical stimulation, massage, traction and paraffin.
The primary risk associated with the passive modalities is skin irritation due to exposure to heat, cold or agents used in the application of modalities, i.e. lotions, pads and/or paraffin. If you have experienced skin sensitivity to heat, cold temperatures and/or lotions or similar products in the past or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS
Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations, trigger point therapy and myofascial release.
Therapeutic interventions are generally quite safe though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise there is also the risk of injury. Though this risk is minimal as you are under the direct supervision of experienced clinical staff, it may still exist.
Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION
Spinal manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax, and may even release the irritation from the nervous system, which may result in other health benefits.

INITIALS_____

As with any healthcare service there are potential reactions and risks, however, as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

DISK HERNIATION

The occurrence of disk herniation during spinal manipulation is highly unlikely. In fact, average disks withstand an average of 23 degrees of rotation and degenerated disks an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 2-3 degrees, this joint would have to fracture to allow any further rotation to occur.

CAUDA EQUINA SYNDROME

It is estimated that the rate of occurrence of the cauda equine syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It is probably higher in patients with a herniated nucleus pulposus, and lower in patients without this anatomic abnormality.

VERTEBROBASILAR ARTERY COMPROMISE

Serious complication of cervical spine manipulation are also rare (none having been reported in any of the clinical trials), but appear to be more common and severe than complication of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebrobasilar artery, leading to stroke or death. The risk is higher for manipulation involving rotation plus extension of the cervical spine than for other types of manipulation, and those persons who have suffered manipulation-related vertebrobasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebrobasilar artery compromise related to cervical spine manipulation is that it occurs one in 1 million manipulations (Hurwitz, 1996; McGregor, 1995).

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT

As your doctor it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examinations and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care. I have reviewed the information provided regarding the benefits and risks of treatment provided at Houston ChiroCare & Rehab. I have been given the opportunity to discuss my questions and/or concerns and by signing below I acknowledge that I understand and accept the risks associated with my treatment.

Patient Signature _____**Date** _____

Guardian's Signature _____ **Date** _____

Houston CHIROCARE & REHAB

(Please list all body parts separately: neck, back, low back, left leg, right hand, left thumb etc.)

1. Body part/ system_____
When did it start? _____
Level of pain? **Slight** 1 2 3 4 5 6 7 8 9 10 **Severe**
How often does it bother you? **Intermittent Constant**
Describe pain: **Sharp Dull Throbbing Burning Achy Excruciating**
Any lost of sensation? Yes / No If yes, where at? _____
Does the pain radiate? Yes / No If yes, where to? _____
What aggravates the symptoms? **Bending Lifting Sitting Walking Exercise Moving Sneezing Coughing**
Other_____
What helps the symptoms? **Medicine Hot Showers Rest Other**: _____
Any lost of sleep due to this condition? Yes / No
Stress cause by condition? Yes / No
Similar conditions in the past? Yes / No

2. Body part/ system_____
When did it start? _____
Level of pain? **Slight** 1 2 3 4 5 6 7 8 9 10 **Severe**
How often does it bother you? **Intermittent Constant**
Describe pain: **Sharp Dull Throbbing Burning Achy Excruciating**
Any lost of sensation? Yes / No If yes, where at? _____
Does the pain radiate? Yes / No If yes, where to? _____
What aggravates the symptoms? **Bending Lifting Sitting Walking Exercise Moving Sneezing Coughing**
Other_____
What helps the symptoms? **Medicine Hot Showers Rest Other**: _____
Any lost of sleep due to this condition? Yes / No
Stress cause by condition? Yes / No
Similar conditions in the past? Yes / No

3. Body part/ system_____
When did it start? _____
Level of pain? **Slight** 1 2 3 4 5 6 7 8 9 10 **Severe**
How often does it bother you? **Intermittent Constant**
Describe pain: **Sharp Dull Throbbing Burning Achy Excruciating**
Any lost of sensation? Yes / No If yes, where at? _____
Does the pain radiate? Yes / No If yes, where to? _____
What aggravates the symptoms? **Bending Lifting Sitting Walking Exercise Moving Sneezing Coughing**
Other_____
What helps the symptoms? **Medicine Hot Showers Rest Other**: _____
Any lost of sleep due to this condition? Yes / No
Stress cause by condition? Yes / No
Similar conditions in the past? Yes / No

INITIALS: _____