

PATIENT FORMS

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

DOB : / / _____

Driver's License # : _____ **State:** _____

Marital Status: **S** **M** **W** **Spouse's Name:** _____

Your Employer: _____ **Occupation:** _____

Employer Address: _____

Referred By: _____ **Primary Care Provider:** _____

INSURANCE INFORMATION

Insurance Type: **Health** **Personal Pay** **PI/Auto** **Workers Comp** **Medicare**

Insurance Name: _____

Member #: _____ **Group #:** _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature: _____

Date: _____

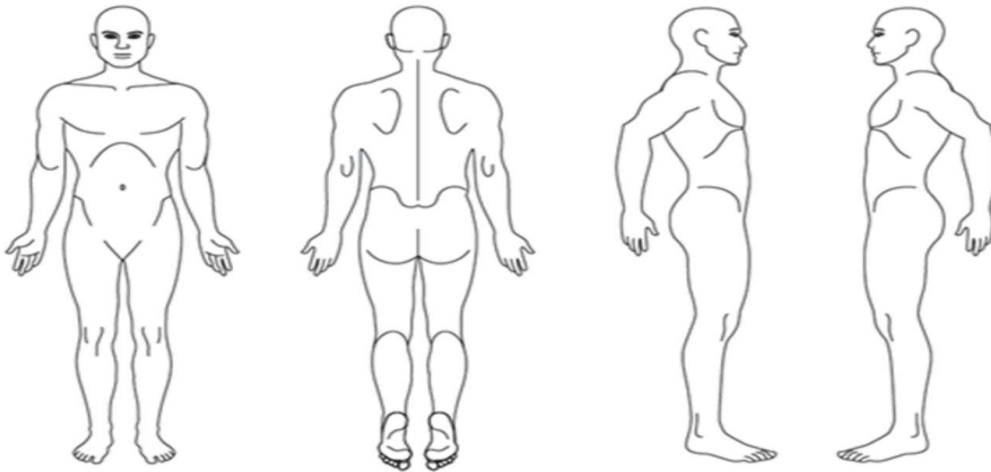
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Today's problem will be filed as: Insurance/Self Pay Auto Accident Workmans Compensation

2. What is your primary area of concern/pain? _____

3. Indicate on the drawings below where you have pain/symptoms:



4. How would you describe the type of pain?

- | | | | |
|--------------------------|----------|--------------------------|---------------------------|
| <input type="checkbox"/> | Achy | <input type="checkbox"/> | Stiff |
| <input type="checkbox"/> | Burning | <input type="checkbox"/> | Tingly |
| <input type="checkbox"/> | Diffuse | <input type="checkbox"/> | Sharp with motion |
| <input type="checkbox"/> | Dull | <input type="checkbox"/> | Shooting with motion |
| <input type="checkbox"/> | Numb | <input type="checkbox"/> | Stabbing with motion |
| <input type="checkbox"/> | Sharp | <input type="checkbox"/> | Electric-like with motion |
| <input type="checkbox"/> | Shooting | <input type="checkbox"/> | Other: _____ |

5. How long have you had this problem? _____

6. How do you think your problem began? _____

7. How often do you experience your symptoms?

- | | | | |
|--------------------------|------------------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | Intermittently (1-25% of the time) | <input type="checkbox"/> | Frequently (50-75% of the time) |
| <input type="checkbox"/> | Occasionally (26-50% of the time) | <input type="checkbox"/> | Constantly (75-100% of the time) |

8. On a scale of 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 (please circle)

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. How are your symptoms changing with time?

Getting Worse Staying the Same Getting Better

Allen Chiropractic New Patient Forms

817-416-9800

12. What is your: **Height:** _____ **Weight:** _____
Date Of Birth: _____ **Occupation:** _____

13. How would you rate your overall health?
 Excellent Very Good Good
 Fair Poor

14. Rate your level of exercise/activity:
 Strenuous Light
 Moderate None

15. Indicate if you suffer from or have immediate family members with any of the following:
 Lupus Cancer Heart Problems
 ALS Diabetes Rheumatoid Arthritis

16. For the conditions listed below, please check the "past" column if you have had the conditions in the past; if you presently have the condition listed below, please check the "present" column.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Drug / Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss Of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis / Eczema / Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDs
<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss/Gain			
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss Of Appetite			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/GallBladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control (Please Specify)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue			_____
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness			

17. List all prescription and over-the-counter medications you are currently taking:

18. List all nutritional supplements you are currently taking:

19. List all surgical procedures you have undergone:

20. What activities do you do at work?

Sit	<input type="checkbox"/>	Most of the day	<input type="checkbox"/>	Half of the day	<input type="checkbox"/>	Small Amounts
Stand	<input type="checkbox"/>	Most of the day	<input type="checkbox"/>	Half of the day	<input type="checkbox"/>	Small Amounts
Computer work	<input type="checkbox"/>	Most of the day	<input type="checkbox"/>	Half of the day	<input type="checkbox"/>	Small Amounts
On The Phone	<input type="checkbox"/>	Most of the day	<input type="checkbox"/>	Half of the day	<input type="checkbox"/>	Small Amounts
Driving	<input type="checkbox"/>	Most of the day	<input type="checkbox"/>	Half of the day	<input type="checkbox"/>	Small Amounts
Other Activities	<input type="checkbox"/>	Manual Labor	<input type="checkbox"/>	Reading	<input type="checkbox"/>	Frequent Travel

21. What Activities do you enjoy outside of work?

22. Have you ever been Hospitalized? Yes No

If yes, Why? _____

23. Have you had Past Trauma such as Car Accidents (ever?), Falls, Sport Injuries, ect?

Yes No

If yes, What and When? _____

24. Is there anything else you wish to let your Doctor know about your visit today?

Patient/Guardian Signature _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA NOTICE that is available to you at the Front Desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of their own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care, given the patient is in the office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to ensure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent form for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and agree to these policies and procedures:

NAME OF PATIENT

DATE

ALLEN CHIROPRACTIC

1244 William D Tate Ave.

Grapevine, TX 76051

PH: 817-416-9800

FX: 817-416-8637

Email: allenchiro1244@gmail.com

24 HOUR MESSAGE CANCELLATION AND SAME DAY NO-SHOW POLICY

We aim to provide our clients with the highest quality of service and pride ourselves on our exceptional team.

If you cancel your massage appointment LESS THAN 24 HOURS AHEAD OF OR ON THE SAME BUSINESS DAY of your scheduled appointment, or FAIL TO SHOW UP, we not only lose your business, but also potential business of other clients who may have taken your scheduled reservation time.

A \$25.00 FEE will be charged to your account for failure to give appropriate notice or failure to show up for your scheduled massage appointment.

PLEASE NOTE: This also applies even if your appointment is booked the same day and you call back to cancel, or do not show up, within that same day.

Thank you for your cooperation and understanding of this policy.

By signing this, I acknowledge that I have read and understand the massage cancellation policy.

Signature _____ Date _____