



# TO THE New Patient

## OUTLINE OF PROCEDURES FOR CARE

### **STEP ONE:**

All new patients are requested to fill out this personal health history questionnaire.

### **STEP TWO:**

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

### **STEP THREE:**

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

### **STEP FOUR:**

The doctor will advise you if additional laboratory tests or x-rays are needed.

### **STEP FIVE:**

You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of

how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

### **STEP SIX:**

Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

### **STEP SEVEN:**

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

### **STEP EIGHT:**

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

**PERSONAL HISTORY**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F  
 Cell Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
 Check One:  Married  Single  Widowed  Divorced  Separated  
 Business Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Type of Work \_\_\_\_\_ Name and Ages of Children \_\_\_\_\_  
 Referred To This Office By: \_\_\_\_\_  
 Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Who Is Responsible For Your Bill, You and  Spouse  Workers' Comp.  Auto Insurance  Medicare  Medicaid  
 Personal Health Insurance (Name) \_\_\_\_\_  Health Card # \_\_\_\_\_  
 Insured Person's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Unwanted Health Condition \_\_\_\_\_  
 Other Doctors Seen For This Condition:  Yes  No \_\_\_\_\_ Who? \_\_\_\_\_  
 Type of Treatment: \_\_\_\_\_ Results: \_\_\_\_\_  
 When Did This Condition Begin? \_\_\_\_\_ Has This Condition Occurred Before?  Yes  No  
 Is Condition:  Job Related  Auto Accident  Home Injury  Fall  Other: \_\_\_\_\_  
 Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  
 Have You Made A Report of Your Accident To Your Employer:  Yes  No  
 Drugs You Now Take:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine  
 Insulin  Other \_\_\_\_\_  
 Do You Wear A Shoe Lift?  Yes  No  
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? \_\_\_\_\_

**PAST HEALTH HISTORY**

Please Check and Describe:  
 Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery  
 Broken Bones  Other \_\_\_\_\_  
 Major Accident or Falls: \_\_\_\_\_  
 Hospitalization (Other Than Above): \_\_\_\_\_  
 Previous Chiropractic Care:  None  Doctor's Name & Approximate Date of Last Visit \_\_\_\_\_

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox     | <input type="checkbox"/> Pleurisy         |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           |

**INTAKE**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

Have you been tested HIV positive?  Yes  No

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL CODE**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

**FEMALES ONLY:**

When was your last period? \_\_\_\_\_

Are you pregnant?

- Yes  No  Not Sure

**GENITO-URINARY CODE**

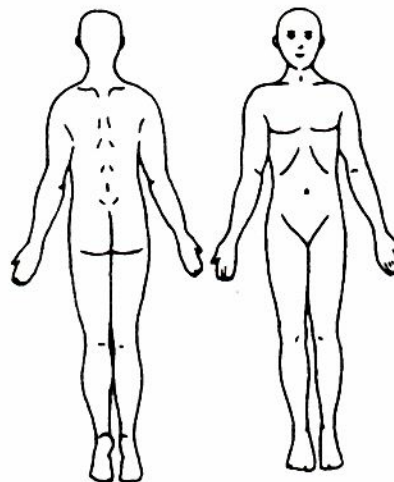
- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

**NERVOUS SYSTEM CODE**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

**C-V-R CODE**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke



Please outline on the diagram the area of your discomfort

**GENERAL CODE**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

**EENT CODE**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

**GASTRO-INTESTINAL CODE**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**MALE/FEMALE CODE**

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FAMILY HISTORY**

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

**DO NOT WRITE BELOW THIS LINE**

ANALYSIS:

DIAGNOSIS:

Patient Accepted:  Yes  No  Referred

Doctor's Signature \_\_\_\_\_

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief  
Care

Corrective  
Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Date

Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



**Relief Care**

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.



**Corrective Care**

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.*

*I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.*

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

Consent to Treat a Minor \_\_\_\_\_

Date \_\_\_\_\_

Guardian or Spouse's  
Signature of Authorizing Care \_\_\_\_\_

Date \_\_\_\_\_

# **The Texas Health Clinics 1** **Practice's Requirements**

## The Practice

- a) Is required by Federal Law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal Law.
- c) Is required to abide by the terms of this Privacy Notice.
- d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy notice provisions effective for your entire PHI that it maintains.
- e) Will distribute any revised Privacy Notice to your prior implementation.
- f) Will not retaliate against you for filing a complaint.

## **Effective Date**

This Notice is in effect as of February 15, 2010.

## **Patient Acknowledgment**

By subscribing my name below, I acknowledge receipt of a copy of this Notice, my understanding and my agreement to its terms.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date