Allen Chiropractic New Patient Forms 817-416-9800

PATIENT FORMS

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

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

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB : / / **Soc. Sec. # - -**

Driver's License # : State:

Emergency Contact Name: Phone Number:

Your Employer: Occupation:

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

Referred By: **Primary Care Physician:**

INSURANCE INFORMATION

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

Insurance Name:

Member #: **Group #:**

Insurer's Name (If Different From Patient): Relationship To Patient:

Insurer's DOB: / / Insurer's Soc. Sec. #: - -

Insurer's Employer:

Person Responsible for Account:

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:**

_____ _____

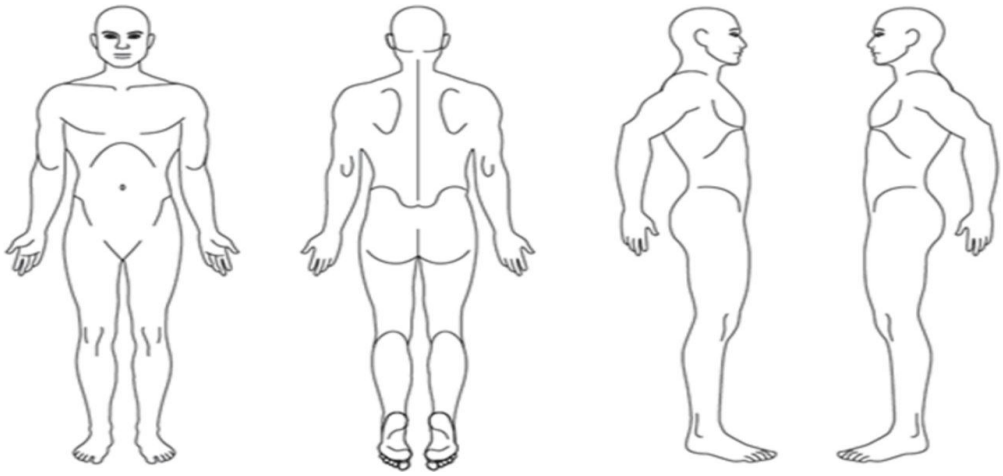
PATIENT INTAKE FORM

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?

- ☐ Achy
- ☐ Burning
- ☐ Diffuse
- ☐ Dull
- ☐ Numb
- ☐ Sharp
- ☐ Shooting
- ☐ Stiff
- ☐ Tingly
- ☐ Sharp with motion
- ☐ Shooting with motion
- ☐ Stabbing with motion
- ☐ Electric-like with motion
- ☐ 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?

- ☐ Intermittently (1-25% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Frequently (50-75% of the time)
- ☐ 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

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

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	☐	Most of the day	☐	Half of the day	☐	Small Amounts	
Stand	☐	Most of the day	☐	Half of the day	☐	Small Amounts	
Computer work	☐	Most of the day	☐	Half of the day	☐	Small Amounts	
On The Phone	☐	Most of the day	☐	Half of the day	☐	Small Amounts	
Driving	☐	Most of the day	☐	Half of the day	☐	Small Amounts	
Other Avtivities	☐	Manual Labor	☐	Reading	☐	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 MASSAGE 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_____