Fort Bend Injury Clinic, PLLC Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Cell Phone Carrier (for appointment reminder texts): _____

Email Address: _____

Age: _____ Race: _____ ❑ Male ❑ Female

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Preferred Language: _____

Marital Status: ❑Married ❑Single ❑Divorced ❑Separated ❑Other: _____

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation: _____ Your Employer: _____

Referred to this office by: ❑Friend/Family Member – Name: _____

❑Google ❑Yellow Pages ❑Mail ❑Clinic Location ❑Other: _____

Payment for Services will be by: ❑Health Insurance ❑Automobile Insurance ❑Worker's Comp.

Primary Care Physician Name: _____ City: _____

Name of Insurance Co.: _____ Insured's Name: _____

Insured's Date of Birth: _____ Relationship to Insured: _____

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition: _____

Date of Last Physical Exam: _____ Height: _____ Weight: _____

SURGICAL HISTORY: 1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Have you ever had a metal implant? ❑Yes ❑No Have you ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____ Date: _____

❑Job ❑Auto ❑Other 2. _____ Date: _____

❑Job ❑Auto ❑Other 3. _____ Date: _____

SOCIAL HISTORY

Have you drink alcoholic beverages? ❑Yes ❑No If so, how much per week?: _____

Do you use any tobacco products/smoke? ❑Yes ❑No If so, packs per day: _____

Do you take vitamin supplements? ❑Yes ❑No If so, please list: _____

Do you consume caffeine? ❑Yes ❑No If so, how much per day?: _____

Do you exercise? ❑Yes ❑No If so, what is the frequency and type of exercise?: _____

What are your hobbies: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS

Please rate your symptoms 1-10 (1 being least serious)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

SYMPTOMS ARE WORSE IN: ❑MORNING ❑AFTERNOON ❑NIGHT

WHEN AND HOW OCCURRED?: _____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT

❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: _____

SYMPTOMS HAVE PERSISTED FOR #: ____ HOUR(S) ____ DAY(S) ____ WEEK(S) ____ MONTH(S) ____ YEAR(S)

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?: _____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?: _____

_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑NO ❑YES WHAT KIND?: _____

ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES WHAT KIND?: _____

ARE YOU PREGNANT? ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD: _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT <u>AGGRAVATE</u> YOUR CONDITION:

❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD

❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT <u>RELIEVE</u> YOUR CONDITION:

❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY <u>ADDITIONAL SYMPTOMS</u> YOU MAY BE EXPERIENCING:

❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion

❑constipation ❑depression/weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever

❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste

❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms

❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of your policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____