Lordex Spine Institute

212 Gulf Fwy. South, Suite G1, League City, TX 77573

Name________________________________ ❑Male ❑Female ❑Married ❑Single ❑Divorced **Today's Date**____/____/____

Address____ City _________________ State______ Zip____________

Home Phone: _______________________ Cell Phone___________________[Carrier ☐AT&T ☐Verizon ☐Sprint ☐T-Mobile ☐__________]

SSN# _________________________ D.O.B._________________ Age___________ Referred by________________________

Occupation__________________________Employer______________________________Work Phone:____________________

E-mail ____

May we have your permission to update your medical doctor regarding your care at this office? ❑Yes ❑No

Primary Care Physician ____ Phone: ___________________________________

Have you ever received Chiropractic Care? ❑Yes ❑No If yes, how long ago?_____________________________________

1. Chief Complaint: ____

Location of Complaint: ____

Complaint began when and how? ____

Please circle the quality of the complaint/pain:

dull aching sharp shooting burning throbbing deep nagging other _________________________________

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?____________________________

Do you have any numbness or tingling in your body? Where? ____

How frequent is complaint present, how long does it last? ____

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

Have you ever had the same or a similar condition? ❑Yes ❑No If yes, when and describe:_______________________

____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: __________________

____

3. Past Health History:

A. Previous illnesses you've had in your life: ____

____

B. Previous injury or trauma:____

Have you ever broken any bones? Which? ____

C. Allergies:____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? ________________________

Are you Pregnant Now? ❑YES ❑ NO

1. Family Health History:

Associated health problems of relatives *(circle)*: Cancer Heart Diabetes Other____________________

Deaths or Health Problems in immediate family:

Mother	❑Cancer	❑ Heart	❑ Diabetes	Other________________
Father	❑Cancer	❑ Heart	❑ Diabetes	Other________________
Sibling	❑Cancer	❑ Heart	❑ Diabetes	Other________________

2. Social and Occupational History:

A. Level of Education: ❑high school ❑some college ❑college graduate ❑post graduate studies

B. Job description: ____

C. Work schedule: ____

D. Recreational activities: ____

E. Lifestyle *(circle)*:

How often do you exercise?	❑Daily	❑Weekly	❑Sometimes	❑Never
How often do you drink alcohol?	❑Daily	❑Weekly	❑Sometimes	❑Never
How often do you smoke?	❑Daily	❑Weekly	❑Sometimes	❑Never
Do you use recreational drugs?	❑Yes ❑No			
How is your diet?	❑Healthy	❑Healthy Sometimes	❑ Fast Food	

Do you have Insurance? ❑YES ❑ NO Insurance Carriers Name:____________________________

QUADRUPLE VISUAL ANALOGUE SCALE

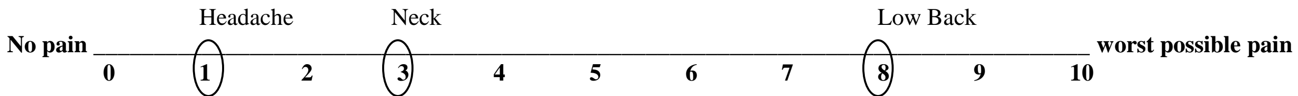
Patient Name ____ Date ___________________________

Please read carefully:

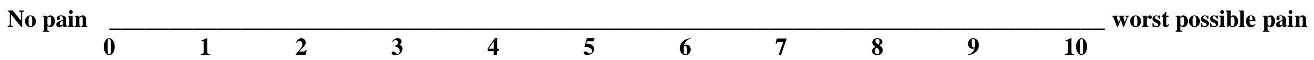
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

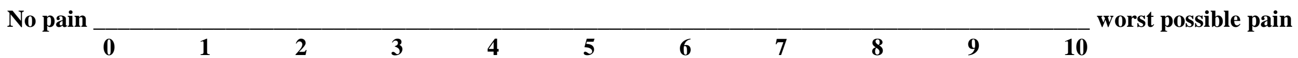
Example:



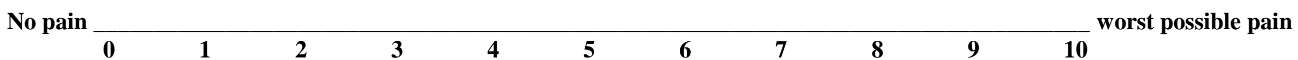
1 – What is your pain RIGHT NOW?



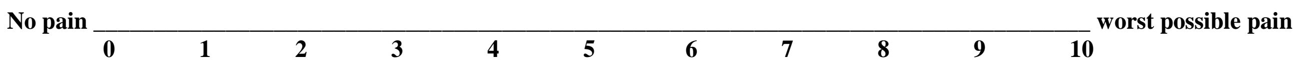
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

____

____

Please Check All Conditions You Currently Have or Have Had

GENERAL APPEARANCE
❑ Weight Loss ❑Weight Gain ❑Change in Sleeping Patterns ❑Change in Activity Capacity

NEUROLOGICAL
❑ Anxiety ❑ Headaches ❑ Depression ❑ Meningitis ❑ Paralysis ❑ Seizure ❑ Stroke ❑ Tingling ❑ Tremors ❑ Memory Loss ❑ Fainting spells ❑ Dizziness ❑Head injuries ❑ Blackouts or near blackouts ❑ Change in sensation anywhere on your body ❑ Localized weakness or numbness

EARS, EYES, NOSE, & THROAT
❑Hay fever ❑Glaucoma ❑Polyps ❑Allergy ❑Cataracts ❑Goiter ❑Hoarseness ❑Double vision ❑Gum problems ❑Eye problems ❑Ear Infections ❑Glasses/contacts ❑Hearing Loss ❑Ear discharge/pain ❑Frequent nosebleeds ❑ Ringing in your ears ❑Sinus infections ❑Swollen glands

CARDIOVASCULAR
❑Angina ❑Leg cramps ❑Ankle swelling ❑Awakening at night short of breath & getting out of bed ❑Cardiac catheterization ❑Cold hands or feet ❑Congenital heart defects ❑Dizziness when standing up quickly ❑Heart attacks ❑Heart failure ❑High or low blood pressure ❑Irregular heart rate ❑Purple fingers or lips ❑Leg pain that resolves with rest ❑Heart palpitations ❑Varicose veins ❑Chest pains ❑Murmurs

RESPIRATORY
❑Asthma ❑Breathlessness when lying flat ❑Prolonged cough ❑Coughing up blood ❑Emphysema ❑Shortness of breath ❑Tuberculosis ❑Pneumonia ❑Frequent infections (bronchitis) ❑Wheezing ❑Pleurisy

SKIN
❑Abscess ❑Dandruff ❑Acne ❑Oily skin ❑Boils ❑Rashes ❑Hives ❑Dry skin ❑Lumps ❑Psoriasis ❑Jaundice ❑Athlete's foot ❑Excessive body odor ❑Excessive sweating ❑Fungal infections ❑Nail problems ❑Moles- irregular ❑Moles - change/new

KIDNEYS & URINARY TRACT
❑Blood in urine ❑Brown urine ❑Dribbling after urination ❑Painful urination ❑Excessive thirst ❑Involuntary urination/incontinence ❑Urinating frequently (day) ❑Urinating frequently (night) ❑Urine hesitancy ❑Weak flow ❑Frequent bladder infections ❑Kidney disease ❑Kidney stone

ENDOCINE
❑Diabetes ❑Sickle cell ❑Abnormal body hair ❑Changes in skin texture ❑Cold intolerance ❑Heat intolerance ❑History of "borderline" diabetes

MUSCULOSKELETAL
❑Anemia ❑Arthritis ❑Back pain ❑Bursitis ❑Gout ❑Joint aches ❑Neck pain ❑Tendinitis ❑Abnormal Blood Counts ❑Blood clots in legs/lungs ❑Bone Marrow Biopsy ❑Easy Bleeding ❑Easy bruising ❑Joint swelling ❑Morning stiffness ❑Muscle aches

GASTROINTESTINAL
❑Diarrhea ❑Reflux ❑Ulcers ❑Hepatitis ❑Abdominal pain ❑Anal fissures ❑Black tarry stools ❑Vomiting blood ❑Constipation ❑Nausea ❑Problems swallowing ❑Hiatal Hernia ❑Intestinal obstruction ❑Liver disease ❑Hemorrhoids ❑Red blood after bowel movements ❑ Gallstones ❑Vomiting ❑Heartburn ❑Indigestion

MALE & FEMALE
❑Painful sexual intercourse ❑Loss of sexual interest ❑Unprotected sex ❑Groin itching ❑Sexually transmitted diseases

MALES ONLY
❑Hernia ❑Sterility ❑Bloody ejaculation ❑Inability to complete intercourse ❑Lump on testicle ❑Penile discharge ❑Problems maintaining or keeping an erection ❑Prostate disease ❑Sores on penis or warts ❑Testicular pain ❑Testicular swelling

FEMALES ONLY
❑D & C ❑Hot flashes ❑Hernia ❑Fibroids ❑Abnormal bleeding between cycles ❑Abnormal pap smear ❑Bleeding after intercourse ❑Complications w/ pregnancy ❑PMS ❑Endometriosis ❑Heavy bleeding during cycles ❑Discharge from breast ❑Ovarian cysts ❑Pelvic Inflammatory Disease ❑Postmenopausal symptoms ❑Vaginal discharge ❑Vaginal Dryness ❑Vaginal warts

Not Listed Above:____

____

Provider's Comments: ____

____

Comprehensive Medical History

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature ____ Date ____________________

Doctors Signature ____ Date ____________________

History Documentation - Review of Systems:
99202 = P/N for system 99203 = 2-9 systems 99204/99205 = 10 systems

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 Patient Health Information 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 all 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 his or her 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 in this 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 assure 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 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 will be used and I agree to these policies and procedures.

Patient Signature Date

Informed Consent to Chiropractic Treatment

<u>The nature of chiropractic treatment:</u> The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or hydrotherapy may also be used.

<u>Possible Risks:</u> As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

<u>Probability of risks occurring:</u> The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

<u>Other treatment options which could be considered</u> may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

<u>Risks of remaining untreated:</u> Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

<u>Unusual risks:</u> I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

______________________________	______________________________	__________
Printed Name	**Signature**	**Date**

OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

Our office will accept your insurance on assignment. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office DOES NOT guarantee your insurance policy or payments.

2. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.

3. You are required to sign an "Assignment of Benefits" form and any other forms required by your insurance company on your first visit.

4. If your insurance company requires their own claim form(s), you are required to bring in the completed form(s) by your second visit and then as needed.

5. You will be responsible for your deductible and co-payment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.

6. Your insurance should pay within 60 days from the date in which it was filed.

7. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to pay.

8. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

9. Any overpayments made by your insurance company which credits your account will be refunded to them. However, any overpayments or errors in amounts paid which does not credit your account will be your responsibility.

10. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay, after your account has been paid, refunds will be sent to you.)

I have read and understand the policy regarding insurance assignments. I realize that I am responsible for all charges incurred by me at this office.

____ _________________________

Signature Date