

Today's Date: ___/___/___

Lordex Spine Institute

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

Name _____ Male Female Married Single Divorced

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone _____ [Carrier: AT&T Verizon T-Mobile _____]

SSN# _____ D.O.B. _____ Age _____ Referred by _____

Occupation _____ Employer _____ Work Phone: _____

E-mail _____

Do you have Insurance? Yes No Insurance Carriers Name: _____

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 Yes No Which? _____

C. Allergies: _____

D. Medications

Reason for taking

_____	_____
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date

_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Are you Pregnant Now? Yes No

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

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

4. 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_____

5. 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

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:

	Headache	Neck		Low Back								
No pain	0	1	2	3	4	5	6	7	8	9	10	worst possible pain

1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

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

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

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

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

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 Heart palpitations Varicose veins Chest pains
Murmurs Leg pain that resolves with rest Purple fingers or lips

RESPIRATORY

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

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 Weak flow Urinating frequently (day)
Urinating frequently (night Urine hesitancy Frequent bladder infections Kidney disease Kidney stone

ENDOCRINE

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 Testicular pain Testicular swelling Lump on testicle Penile discharge
Problems maintaining or keeping an erection prostate disease Sores on penis or warts

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 _____

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 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 needs 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 affect 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 have been trained in 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 you 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

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device 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.

Possible Risks: As with any health care procedure, complications are possible following 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.

Probability of risks occurring: 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”.

Other treatment options which could be considered 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 reactions to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: 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.

Unusual risks: 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 hereby 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 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 be paid within 60 days of 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. If 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 do 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