LORDEX® SPINE INSTITUTE

Dr. Brandt. L. Spies, D.C.
212 Gulf Fwy S. Suite G1
League City, Texas 77573
281.535.5673
fax: 832.932.5490

Patient Record Update

Name: ______________________________ Phone: ______________________

Address: ______________________ City: __________ State: ______ Zip: __________

E-Mail: ______________________

Complete the following only if the information has changed since your last visit.

Occupation: ______________________ Employer: ______________________

Employer's Address: ______________________ City: __________ State: ______ Zip: __________

Work Phone: ______________________

Spouse: ______________________ Spouse's Employer: ______________________

Authorization and Release

Health Insurance Coverage: ☐ Yes ☐ No Name of Health Insurer: ______________________

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. I understand that interest is charged on overdue accounts at the annual rate of (16%).

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 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. If there is anyone you do not want to receive your medical records, please inform our office.

Signature: ______________________ Date Signed: ______________________

Purpose of this appointment:

What is your major symptom? ______________________________

Is this the same problem you were originally under care for? ☐ Yes ☐ No

If yes, are there any additional symptoms? ______________________________

How did it originally occur? ______________________________

If this is a recurrence, when was the first time you noticed this problem? ______________________________

On a scale of 1 to 10, with 10 being the most severe, how would you rate your pain? ______________________________

Has it become worse recently? ☐ Yes ☐ No ☐ Gradually Worse ☐ Same ☐ Better

Describe the pain: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing

☐Other: ______________________________

How frequent is the pain/condition? ☐Constant ☐ Intermittent ☐Daily ☐ Night Only

How long does it last? ☐ All Day ☐Few Hours ☐ Minutes

Is there anything you can do to relieve the problem? ☐No ☐Yes:______________________________

If no, what have you tried to do that has not helped?______________________________

What makes the problem worse? ☐Standing ☐Sitting ☐ Lying ☐Bending ☐Lifting ☐Twisting

☐ Other: ______________________________

Other doctors seen for this condition: ☐No ☐Yes:______________________________

Are there any other conditions or symptoms that may be related to your major symptom?

☐No ☐Yes:______________________________

Are there other unrelated health problems? ☐No ☐Yes:______________________________

What medications or drugs are you taking? ______________________________

Have you had any broken bones? ☐No ☐Yes, list and give dates ______________________________

Have you had any major accidents you have had other than those that might be mentioned above?

☐No ☐Yes, list and give dates ______________________________

To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ☐No ☐Yes:______________________________

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐No ☐Yes ☐Uncertain

Are there any other issues the Doctor should be aware of before continuing your treatment?

☐No ☐Yes:______________________________

Doctor's Signature:______________________________ **Date:** ______________________________

https://LSILC.com