Focal Point Chiropractic
1210 Allendale
Pasadena, Tx 77502
832-582-5301

WELCOME

DATE _____

PATIENT INFORMATION

TITLE: ☐MR. ☐MRS. ☐MR. ☐MISS ☐DR. ☐OTHER_____ MARITAL STATUS: ☐SINGLE ☐MARRIED ☐OTHER_____

FIRST NAME M.I. LAST NAME

DATE OF BIRTH: GENDER: ☐MALE ☐FEMALE SOCIAL SEC. #:

STREET ADDRESS: CITY: STATE: ZIP CODE:

PHONE NUMBERS

HOME: WORK: CELL:

EMAIL ADDRESS:

SPOUSE/EMERGENCY CONTACT

FIRST NAME M.I. LAST NAME

PHONE NUMBERS

HOME: WORK: CELL:

EMPLOYEE / INSURANCE ***PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD***

STATUS: ☐EMPLOYED ☐SELF-EMPLOYED ☐UNEMPLOYED ☐FT/PT STUDENT ☐MILITARY ☐RETIRED ☐DISABLED

NAME OF EMPLOYER: OCCUPATION:

WHO IS RESPONSIBLE FOR YOUR BILL?

☐SELF ☐HEALTH INSURANCE ☐SPOUSE ☐WORKER'S COMP ☐AUTO INS. ☐MEDICARE ☐MEDICAID ☐OTHER_____

PRIMARY CARE PHYSICIAN:

☐ **WORKPLACE INJURY**

HAVE YOU FILED AN INJURY REPORT WITH YOUR EMPLOYER? ☐YES ☐NO DATE:

☐ **AUTO INJURY** – HAVE YOU SUPPLIED US WITH THE AUTO ACCIDENT REPORT (FR-10) AND LEGAL REPRESENTATION INFORMATION? ☐YES ☐NO

CONSENT TO TREAT A MINOR

NAME OF MINOR PATIENT: DATE:

SIGNATURE OF PARENT / GUARDIAN AUTHORIZING CARE:

Our purpose is to help you achieve your highest level of health by providing services that seek to restore and maintain your body to its optimum function. Our initial objective is to determine if you are in the right office. We must consider what issues you are having as well as what you are seeking. Please fill out the following information completely so the doctor has as much information. Please feel free to ask any questions if you need assistance. We look forward to serving you! The reason for your visit today:

☐ Consultation • This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.	☐ Basic = Cash • Consultation, exam, and adjustments
☐ Comprehensive = Insurance, PI, Auto, Other • More in-depth consultation, Exam, Treatment Plan, Treatments (modalities and adjustments)	☐ Personal Injury Injury that occurred on someone else property
☐ Auto Accident • Injury/is that occurred by an automobile	☐ Other:

PATIENT SIGNATURE: _____

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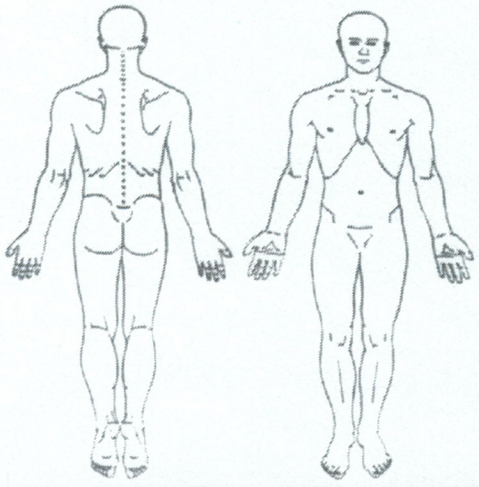
Name: _____ Age: _____ Date of Birth: _____ Today Date: _____
Occupation: _____ How long? _____ Weight: _____ lb. Height: _____ feet _____ inches
Have you had chiropractic care before? ☐ Yes ☐ No When: _____
Reason for today's visit: ☐ Pain ☐ Discomfort ☐ Stiffness ☐ Maintenance Care ☐ Recent Injury ☐ Previous Injury ☐ Other
What happened? _____
When did your complaint(s) first begin? _____ Today is the condition: ☐ Same ☐ Better ☐ Worse
Explain what helps and/or worsens the condition:

_____

Have you experienced this/these complaint(s) before? ☐ Yes ☐ No If yes, when? _____
Place an "**X**" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



4. Where is/are your area(s) of complaint today? Check all that apply	Rate pain and discomfort between 1-10 (1 = minimal, 10 = severe)	Check off the type of Complaint: Radiating	Sharp	Dull	Tingling	Numbnes	Burning	Inflamed/ swollen	Frequency: Constant	Intermittent
☐ Headache/Migraine										
☐ Neck										
☐ Shoulder(s)										
☐ Arm(s)										
☐ Elbow(s)										
☐ Wrist(s)										
☐ Upper Back										
☐ Middle Back										
☐ Lower Back										
☐ Hip(s)										
☐ Sciatica										
☐ Knee(s)										
☐ Ankle(s)										
☐ Other										

Please mark all conditions you have ever had, even if they do not seem to relate your current condition

☐ Headache	☐ Ankle Pain	☐ Cancer_____	☐ Arthritis
☐ Migraines	☐ Foot Pain	☐ Heart Attack/Stroke	☐ Asthma
☐ Jaw Pain	☐ Pins/Needles in Arms & Legs	☐ High Blood Pressure	☐ Colitis
☐ Neck Pain	☐ Numbness in Finger & Toes	☐ Low Blood Pressure	☐ Constipation
☐ Stiff Neck	☐ Cold Feet	☐ Hepatitis	☐ Diarrhea
☐ Shoulder Pain	☐ Tension/Stress	☐ Gallbladder/Liver	☐ Problems Urinating
☐ Hip Pain	☐ Nervousness	☐ Irritable Bowel Syndrome	☐ Cold Sweats
☐ Mid Back Pain	☐ Fatigue	☐ Kidney Disorder	☐ Hot Flashes
☐ Low Back Pain	☐ Irritability	☐ Heartburn	☐ Mood Wings
☐ Arm Pain	☐ Vision Problems	☐ Ulcers	☐ Menstrual Pain
☐ Finger Pain	☐ Light Bother Eyes	☐ Upset Stomach	☐ PMS
☐ Wrist Pain	☐ Fainting/Dizziness	☐ Excessive Thirst	☐ Menstrual Irregularity
☐ Cold Hands	☐ Loss of Balance	☐ Prostate Problems	
☐ Elbow Pain	☐ Problem Sleeping	☐ Sinus Problems	Female Patients:
☐ Leg Pain	☐ Epilepsy	☐ Ringing in Ears	Are you pregnant? ☐ Yes ☐ No
☐ Knee Pain	☐ Diabetes	☐ High Fever	Due Date: _____

PERSONAL LIFESTYLE

Exercise/Sports:	Work Habits:	Other Habits:	
☐ None	☐ Sitting	☐ Smoking	How Often?
☐ Mild	☐ Standing	☐ Drinking	How Often?
☐ Moderate	☐ Light Labor	☐ Coffee/Caffeine	How Often?
☐ Heavy	☐ Heaby	☐ Stress	Level 1-10: _____ Personal: _____ Occupational: _____

On a scale of **Poor, Good, Excellent**, Describe your: Diet: _____ Sleep: _____ General Health: _____
In the past year, have you Lost/Gain any weight? ☐ Yes ☐ No If yes, how much? _____
List Current Prescriptions or Over-the-counter medications:

_____

Any Surgeries, Accidents/Broken Bones, Hospitalizations? If yes, Explain and when: _____
List any Allergies: _____
List any Family History of Illness/Disease: _____
Anything else you would like to tell us: _____

Patient Signature: _____ Date: _____

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INFORM CONSENT:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, modalities, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

POSSIBLE RISKS

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. **These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.**

PROBABILITY OF RISKS OCCURING

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 THAT COULD BE CONSIDERED

- Over-the-counter analgesics.
    - Temporarily relieve pain but do not address the cause of the symptoms. Masking the pain means you may not feel additional damage. 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, injections, and analgesics.
    - Temporarily relieve pain but do not address the cause of the symptoms. Masking the pain means you may not feel additional damage. 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 risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED

Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

CONSENT

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE:

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge I am not pregnant and Focal Point Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

Date of last menstrual period _____ Initials_____

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NOTICE OF PRIVACY POLICY AND HIPAA COMPLIANCE

At Focal Point Chiropractic LLC, we pride ourselves in excellence in client service. As part of our service, we comply with the Health Insurance Portability and Accountability (HIPAA) Act of 1996. This Notice of Privacy Policy and HIPAA Compliance describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully before signing below.

Uses and Disclosures of Your Personal/Health/Medical Information

For Treatment: We may use medical information about you to provide you with treatment or services. *For Payment:* We may use and disclose medical information about you so that the treatment or services you receive may be billed to and payment collected from you, an insurance company or a third party. *As Required By Law:* We will disclose medical information about you when required to do so by federal, state or local law. *For Military and Veterans:* If you are a member of the armed forces, we may release medical information about you as required by military command authorities. *For Worker's Compensation:* We may release medical information about you for worker's compensation or similar programs. *For Lawsuits and Disputes:* If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. *For National Security and Intelligence:* We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Your Rights Regarding Your Personal/Health/Medical Information

Your Right to Inspect and Copy: To inspect and request a copy of your medical information, you must submit your request in writing. *Your Right to Amend:* If you feel the medical information we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support your request. *Your Right to an Accounting of Disclosures:* You have the right to request in writing, a list accounting for any disclosures of your medical information we have made. *Your Right to Request Restrictions:* You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment or service and collection of payment. *Your Right to Request Communications:* You have the right to request how you are communicated with regarding appointments, reminders, payments, discounts or specials, follow ups with a signed Contact Consent Form (separate form). *Your Rights to a Paper Copy of This Notice:* You have the right to a paper copy of this notice at any time.

Contacting the Privacy Officer

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer: Focal Point Chiropractic LLC or with the Secretary of the Department of Health and Human Services.

Changes to This Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. We will provide you with a notice of any revisions or amendments to this policy or changes in the law affecting this policy, electronically within 60 days of the effective date of revision or amendments.

HIPAA Authorization Form

If you provide us permission with a signed HIPAA Authorization Form (separate form), can we use or disclose medical information about you. You may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons authorized. You understand that we are unable to take back any disclosures we have already made prior to revocation. We are required to retain our records of the care we provided to you in Texas for 6 years.

I have read and understand (Insert Company Name)'s Notice of Privacy Policy and HIPAA Compliance and understand this is not a HIPAA Authorization Form or Contact Consent Form, only a notice of my rights.

Client Signature _____ Date _____