Texas Pain & Wellness Chiropractic 121 NW Renfro St, Burleson, TX 76028

TELL US ABOUT YOU **(PLEASE PRINT CLEARLY)**

NAME:		SOCIAL SECURITY #:		DATE:
DATE OF BIRTH:	AGE:	SEX: M F	MARITAL STATUS: M S D W	# OF CHILDREN:
ADDRESS:				
CITY:		STATE:	ZIP:	
HOME PHONE #:		CELL PHONE #:		
E-MAIL ADDRESS:		OCCUPATION:		
COMPANY NAME:		LENGTH OF EMPLOYMENT:		
TYPE OF WORK:	OFFICE/CLERICAL	LIGHT LABOR	MODERATE LABOR	HEAVY LABOR
SPOUSES NAME:				
IN CASE OF EMERGENCY CONTACT NAME:			HOME PHONE #:	

TELL US ABOUT YOUR PAST HEALTH

Y	N	Condition	Y	N	Condition	Y	N	Condition
Y	N	Frequent Neck Pain	Y	N	Alcohol / Drug Abuse	Y	N	Stroke
Y	N	Lower Back Pain	Y	N	Hepatitis	Y	N	Heart Surgery / Pacemaker
Y	N	Severe / Frequent Headaches	Y	N	HIV / Aids	Y	N	Heart Murmur
Y	N	Fainting / Seizures / Epilepsy	Y	N	Shingles	Y	N	Congenital Heart Defect
Y	N	Arm / Leg Pain	Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Rheumatoid Arthritis	Y	N	Chemotherapy	Y	N	Artificial Valves
Y	N	Artificial Limbs / Joints	Y	N	Anemia	Y	N	Rheumatic Fever
Y	N	Asthma / Emphysema	Y	N	Difficulty Breathing	Y	N	Diabetes / Tuberculosis
Y	N	Ulcers / Colitis	Y	N	Psychiatric Problems	Y	N	High / Low Blood Pressure
Y	N	Kidney Problems	Y	N	Heart Attack	Y	N	Fractures
Y	N	Epilepsy	Y	N	Lupus	Y	N	Sports or Other Injuries to Head, Neck or Back
Y	N	Hospitalized	Y	N	Osteoporosis	Y	N	Surgery

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY VITAMINS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS YOU HAVE EVER HAD:

PRIMARY CARE PHYSICIAN: PHONE #:

DATE OF LAST DOCTOR VISIT:

LIST ANY THING YOU MAY BE ALLERGIC TO:

LIST PAST SERIOUS ACCIDENTS:

FAMILY HEALTH HISTORY:	DIABETES	CANCER	HEART DISEASE / STROKE	OTHER:	
DO YOU SMOKE?	Y N	HOW LONG?		PACKS PER DAY:	
ALCOHOL CONSUMPTION?	NEVER	SOCIAL	LIGHT	MODERATE	HEAVY

FOR WOMEN ONLY

DO YOU TAKE BIRTH CONTROL?	Y	N	IF YES, FOR HOW LONG?			
ARE YOU NURSING?	Y	N	ARE YOU PREGNANT	Y	N	DELIVERY DATE?

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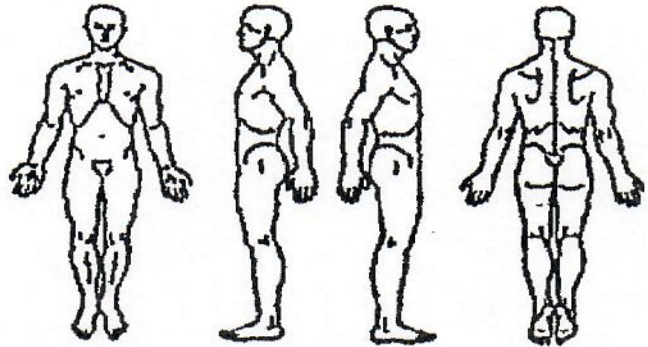
Name ______________________ **REASON FOR THIS VISIT** **Date** __________

THE REASON FOR THIS VISIT IS A RESULT OF (PLEASE CIRCLE):	AUTO ACCIDENT	WORK INJURY	TRAUMA	SPORTS
	GRADUAL ONSET	CHRONIC	OTHER	
DATE OF INJURY / WHEN DID THE CONDITION BEGIN?				
IS THE CONDITION GETTING WORSE?	Y	N		
EXPLAIN WHAT HAPPENED:				

IS THIS CONDITION INTERFERING WITH YOUR (PLEASE CIRCLE):	WORK	SLEEP	DAILY ROUTINE	OTHER:
IF SO, PLEASE EXPLAIN:				

Please darken the body part(s) in which you are currently experiencing symptoms:



CHIEF COMPLAINTS

	Where does it hurt?	ONSET (When did the pain start?)	PROVOCATIVE (What makes it worse?)	PALLIATIVE (What makes it better?)	QUALITY (Achy, stiff, sharp, burning, etc.)	RADIATION (Does the pain go down your arm / leg?)	SEVERITY (1 – 10)	TEMPORAL (When does it hurt? Constant, On and off)
1.								
2.								
3.								
4.								
5.								
6.								
7.								

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AUTHORIZATIONS: Name: ______________________ Date: ________

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment of this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable. Unpaid balance of more than 90 days will be turned over to a collections agency.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT:		
INSURANCE COMPANY:		PHONE #:
GROUP #:	ID #:	

Signature______________________ **Date** __________

Guardian Signature______________________ **Date** __________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Informed Consent to Chiropractic Treatment

The Nature of the Chiropractic Adjustment

We will use our hands or a mechanical devise upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you crack your knuckles. You may feel or sense movement.

The Material Risks Inherent in Chiropractic Adjustment

As with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some patiens will feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring

Fractures are rate occurrences and generally result from some underlying weakness of the bone or bone disease, which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

The Availability and Nature of Other Treatment Options

Other treatment options for your condition include:

-Self-administered, over-the-counter analgesics and rest
-Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain relievers
-Hospitalization with traction
-Surgery

The Material Risks Inherent in Such Options and the Probability of Such Risks Occurring Include:

Overuse of the over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and pain relievers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self-discipline in not abusing the medicine, and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalizations in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor injured) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain, and exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalizations and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility, which sets up a pain reaction further reducing mobility. In addision, compromise to your neurophysiological integrity and health of your nervous system will continue. Over time these processes may complicate treatment, making the treatment more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT sign until you have read and understand the above.

Please check the appropriate block and sign below:

I have read [ ] or **have had read to me [ ]** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to Texas Pain & Wellness and Alwyn Lorenzo, DC to perform the treatment and acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given to me.

________________________ ________________________
Date Patient Printed Name

________________________ ________________________
Patient Signature Signature of Parent or Guardian of Minor

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Acknowledgement of Receipt of Notice of Privacy Policy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Policies of Texas Pain & Wellness Chiropractic, which describes the practice's policies and procedures regarding the use of any of my Protected Health Information created, received or maintained by the practice.

Printed Name Signature Date

Cancellation and "No Show" Policy

Due to the desirability of appointment times with Texas Pain & Wellness Chiropractic, our office policy maintains that our patients **MUST PROVIDE A 24 HOUR CANCELLATION NOTICE** for all services. Failure to contact the office at least 24 hours in advance or not showing for appointment will result in a fee of $25.00, which must be paid prior to any future appointments.

I understand and agree to the terms of the cancellation policy.

Printed Name Signature Date