



Pecan Country Chiropractic
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Confidential Health Information

Who referred you to our office?

Date

First Name

M.

Last Name

Suffix

Date of Birth

Age

Sex

Home Phone

Cell Phone

Email Address

Street

City

State

Zip Code

Emergency Contact Name

Relationship

Emergency Contact Phone

Marital Status: Single

Married

Divorced

Legally Separated

Widowed

How would you like to be notified about future appointments? Phone Text Email

Your Employer

Address

Work Phone

Occupation

If under the age of 18 please include Parent/Guardian's information below

Name

Date of Birth

Phone Number

Relationship to Patient

Address (If Different from Above)

City

State

Zip Code

This signature is an acknowledgement that the above information is up to date and accurate to the best of your knowledge.

Signature (Patient or Guardian if under 18)

Date

CHIEF COMPLAINT:

What symptoms/conditions have prompted you to seek care today?

What do you believe caused your symptoms/condition?

Are there any other concerns you have regarding your overall health?

Date symptoms/conditions started (Please provide **BEST APPROXIMATION** of month/year if unsure):

What relieves symptoms?:

- Cold Heat Massage Meds Reclining/Resting Sitting Sleep Standing Physical Activity
 Chiropractic Care Other: _____

What aggravates symptoms?: Bending Computer work Lifting Physical activity Sitting Driving

- General movement Standing Sleeping Walking Work duties Home/Chores

Quality/Pain Type:

- Aching Dull Numbing Sharp Sore Stiffening Tingling Other: _____

Is there any radiating pain (pain that starts in one location and travels to another)?

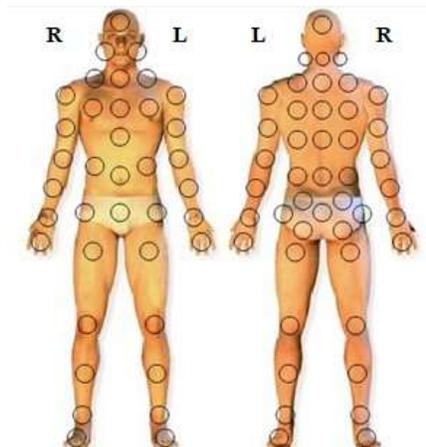
- Yes No

If yes, where?

- R Arm L Arm R Leg L Leg Buttocks Ribs Head/Face

Other: _____

Please mark areas of your current complaint:



Previous treatment for your symptoms/condition: _____

Present Pain Intensity/Severity at its worst:

- 0 1 2 3 4 5 6 7 8 9 10

NO PAIN-----MODERATE PAIN----- WORST PAIN

Timing/Frequency: Constant Frequent Intermittent Occasional During specific activity

REVIEW OF SYSTEMS: (Please Mark All that Apply)

Constitutional:				
<input type="checkbox"/> unexplained weight loss	<input type="checkbox"/> night sweats	<input type="checkbox"/> fatigue	<input type="checkbox"/> malaise	<input type="checkbox"/> lethargy
<input type="checkbox"/> sleeping problems	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> fever	<input type="checkbox"/> itch/rash	<input type="checkbox"/> lump, bump or mass
ENMT:				
<input type="checkbox"/> runny nose	<input type="checkbox"/> nose bleeds	<input type="checkbox"/> sinus pain	<input type="checkbox"/> stuffy ears	<input type="checkbox"/> ear pain
<input type="checkbox"/> ringing in ears	<input type="checkbox"/> bleeding gums	<input type="checkbox"/> sore throat	<input type="checkbox"/> pain with swallowing	
Gastrointestinal:				
<input type="checkbox"/> abdominal pain	<input type="checkbox"/> unintentional weight loss	<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> indigestion	<input type="checkbox"/> bloating
<input type="checkbox"/> cramping	<input type="checkbox"/> food sensitivity/allergy	<input type="checkbox"/> nausea/vomiting	<input type="checkbox"/> diarrhea/constipation	<input type="checkbox"/> inability to pass gas
<input type="checkbox"/> vomiting blood	<input type="checkbox"/> change in stool			
Integumentary:				
<input type="checkbox"/> pruritus (itching)	<input type="checkbox"/> rashes	<input type="checkbox"/> lesions	<input type="checkbox"/> wounds	<input type="checkbox"/> incisions
<input type="checkbox"/> nodules	<input type="checkbox"/> tumors	<input type="checkbox"/> eczema	<input type="checkbox"/> excessive dryness of the skin	
Eyes:				
<input type="checkbox"/> visual changes	<input type="checkbox"/> blind spots	<input type="checkbox"/> eye pain	<input type="checkbox"/> double vision	<input type="checkbox"/> itchy/teary eyes
Cardiovascular:				
<input type="checkbox"/> chest pain	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> exercise intolerance	<input type="checkbox"/> faintness	<input type="checkbox"/> palpitations
<input type="checkbox"/> loss of consciousness	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> low blood pressure		
Endocrine:				
<input type="checkbox"/> hyperthyroid	<input type="checkbox"/> hypothyroid	<input type="checkbox"/> erectile difficulty	<input type="checkbox"/> sweaty	<input type="checkbox"/> diabetes
<input type="checkbox"/> tremor	<input type="checkbox"/> thin hair	<input type="checkbox"/> croaky voice	<input type="checkbox"/> hormonal imbalance	
Genitourinary:				
<input type="checkbox"/> incontinence	<input type="checkbox"/> vaginal discharge	<input type="checkbox"/> painful menses	<input type="checkbox"/> hesitancy of urinating	<input type="checkbox"/> bladder problems
Hematological/Lymph:				
<input type="checkbox"/> anemia	<input type="checkbox"/> excessive bleeding	<input type="checkbox"/> hemophilia	<input type="checkbox"/> purpura (tiny blood spots)	<input type="checkbox"/> bruise easily
Respiratory:				
<input type="checkbox"/> cough	<input type="checkbox"/> wheeze	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> asthma	
Musculoskeletal:				
<input type="checkbox"/> hip pain	<input type="checkbox"/> elbow pain	<input type="checkbox"/> plantar fasciitis	<input type="checkbox"/> muscle cramps	<input type="checkbox"/> arthritis
<input type="checkbox"/> shoulder pain	<input type="checkbox"/> hand numbness/pain	<input type="checkbox"/> heel spurs	<input type="checkbox"/> spinal curvature	<input type="checkbox"/> chest/rib pain
<input type="checkbox"/> arm pain	<input type="checkbox"/> foot numbness/pain	<input type="checkbox"/> sciatica	<input type="checkbox"/> leg pain	<input type="checkbox"/> foot numbness/pain
<input type="checkbox"/> knee pain	<input type="checkbox"/> weakness in arms	<input type="checkbox"/> weakness in legs		
Psychiatric:				
<input type="checkbox"/> depression	<input type="checkbox"/> paranoia	<input type="checkbox"/> anxiety	<input type="checkbox"/> difficulty concentrating	<input type="checkbox"/> mood swings
<input type="checkbox"/> trouble falling asleep	<input type="checkbox"/> trouble staying asleep			
Immunological:				
<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> choking	<input type="checkbox"/> swollen lymph nodes/glands	<input type="checkbox"/> food allergies	<input type="checkbox"/> unusual sneezing
Neurological				
<input type="checkbox"/> headaches	<input type="checkbox"/> numbness	<input type="checkbox"/> tingling	<input type="checkbox"/> balance problems	<input type="checkbox"/> any changes in smell
<input type="checkbox"/> any changes in taste	<input type="checkbox"/> any changes in hearing	<input type="checkbox"/> seizures	<input type="checkbox"/> vertigo/dizziness	<input type="checkbox"/> pins & needles
<input type="checkbox"/> radiating pain	<input type="checkbox"/> blurred vision	<input type="checkbox"/> vision difficulties		

FUNCTIONAL CAPACITY INDEX: (Please select only one (1) per row that best describes your situation)

Pain Intensity	<input type="checkbox"/> No Pain	<input type="checkbox"/> Mild Pain	<input type="checkbox"/> Moderate Pain	<input type="checkbox"/> Severe Pain	<input type="checkbox"/> Worst Possible Pain
Changing Degree of Pain	<input type="checkbox"/> My pain is getting better	<input type="checkbox"/> My pain fluctuates, but is definitely getting better	<input type="checkbox"/> My pain seems to be getting better, but improvement is slow	<input type="checkbox"/> My Pain is neither better or worse	<input type="checkbox"/> My pain is worsening
Lifting	<input type="checkbox"/> No pain; no restrictions	<input type="checkbox"/> Mild pain; no restrictions	<input type="checkbox"/> Moderate Pain; need to go slowly	<input type="checkbox"/> Moderate Pain; need some assistance	<input type="checkbox"/> Severe Pain; need 100% assistance
Walking	<input type="checkbox"/> No Pain on long trips	<input type="checkbox"/> Mild Pain on long trips	<input type="checkbox"/> Moderate Pain on long trips	<input type="checkbox"/> Moderate Pain on short trips	<input type="checkbox"/> Severe Pain on short trips
Sitting	<input type="checkbox"/> I can sit in any chair as long as I like	<input type="checkbox"/> I can only sit in my favorite chair as long as I like	<input type="checkbox"/> Pain prevents me from sitting more than 1 hour	<input type="checkbox"/> Pain Prevents from sitting more than 10 minutes	<input type="checkbox"/> Cannot sit
Standing	<input type="checkbox"/> No pain after several hours	<input type="checkbox"/> Increased pain after several hours	<input type="checkbox"/> Increased pain after 1 hour	<input type="checkbox"/> Increased pain after 1/2 hour	<input type="checkbox"/> Increased pain with any standing
Sleeping	<input type="checkbox"/> Perfect Sleep	<input type="checkbox"/> Mildly Disturbed Sleep	<input type="checkbox"/> Moderately disturbed sleep	<input type="checkbox"/> Greatly disturbed sleep	<input type="checkbox"/> Totally disturbed sleep
Social Life	<input type="checkbox"/> Can do all activities	<input type="checkbox"/> Can do most activities	<input type="checkbox"/> Can do some activities	<input type="checkbox"/> Can do a few activities	<input type="checkbox"/> Cannot do any activities
Traveling/Driving	<input type="checkbox"/> No Pain on long trips	<input type="checkbox"/> Mild Pain on long trips	<input type="checkbox"/> Moderate Pain on long trips	<input type="checkbox"/> Moderate Pain on short trips	<input type="checkbox"/> Severe Pain on short trips
Personal Care (washing, dressing etc.)	<input type="checkbox"/> No pain; no restrictions	<input type="checkbox"/> Mild pain; no restrictions	<input type="checkbox"/> Moderate Pain; need to go slowly	<input type="checkbox"/> Moderate Pain; need some assistance	<input type="checkbox"/> Severe Pain; need 100% assistance
Working	<input type="checkbox"/> Can do usual work; unlimited extra work	<input type="checkbox"/> Can do usual work; no extra work	<input type="checkbox"/> Can do 50% of usual work	<input type="checkbox"/> Can do 25% of usual work	<input type="checkbox"/> Cannot work

POSSIBLE CONTRAINDICATIONS: Please Check Yes, No, or Unsure

Do you have or ever had?	YES	NO	UNSURE	REMARKS:
Articular Hypermobility Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Severe Demineralization of Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Benign Bone Tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are you Taking Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Radiculopathy w/ Progressive Neurological Signs, such as Radiating Pain, Numbness, and Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dislocations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unstable OS Odontodeum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infection of Bones or Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Myelopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cauda Equina Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vertebrobasilar Insufficiency Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Major Artery Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICAL HISTORY:

LIST ANY SURGERIES	<u>Date of Surgery</u>
1)	
2)	
3)	
4)	
5)	
LIST ANY KNOWN ALLERGIES	<u>Date Detected</u>
2)	
3)	
4)	
5)	
LIST ANY CURRENT MEDICATIONS	<u>Reason for Meds</u>
1)	
2)	
3)	
4)	
5)	

ACCIDENT HISTORY: Please List Most Recent Accidents First

Accident Description	Date of Accident	Treatment Received?
1)		
2)		
3)		
4)		
5)		

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

SIGNATURE: _____

DATE: _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Texas.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effect until revoked by both parties.

Patient/Insured Signature

Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. Like any other healthcare procedure, there are risks and complications that may occur.

I, _____ of do hereby give my consent to the performance of conservative examination and noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Active therapy, exercises, orthopedic tests, range of motion testing and passive and resistant stretches may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are certain risks and complications which may arise during chiropractic manipulation and therapy. These complications can include:

Soreness: I am aware that, like exercise, it is common to experience muscle and/or joint soreness after the first few treatments. Any new development of other symptoms should be reported to the doctor immediately.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. The most common injury we have encountered is **rib sprain/strain** and more rarely, fracture. This injury is more common with those with any history of smoking and/or previous rib cage injuries but can still occur in healthy individuals. Please inform the staff at Pecan Country Chiropractic of any history of short term or long-term smoking habits or injuries suffered to the ribs and sternum (chest bone), including surgical procedures.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Pecan Country Chiropractic and its employees will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to their attention, it is your responsibility to inform them. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that results from treatment are directly affected by the inability to maintain any prescribed treatment plans and frequency of treatment recommended by the doctor. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor’s choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint stability or serious disk injury. Surgical risks may include unsuccessful outcome, increased and/or new complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient

Date

Signature of Witness

Date