Simmons Chiropractic

108 Sterling

Dayton TX 77535

936-258-5020

Date:_____

Patient Name:_____ Date of Birth_____

Age:_____ Social Security #:_____ Marital Status_____

Spouse's Name:_____

Mailing Address_____

_____

Home Phone_____ Cell Phone_____

Email Address_____

Occupation:_____Employer_____

Who should we contact in case of emergency?

Name_____ Phone_____

Who can we thank for referring you to us?_____

Primary Insurance Name:_____Phone #_____

Insurance Address:_____

Policy Holders Name:_____Date of Birth_____

Insurance ID#_____Group #_____

Secondary Insurance Name:_____Phone _____

Insurance Address:_____

Policy Holders Name:_____Date of Birth_____

Insurance ID#_____Group #_____

I hereby authorize assignment of insurance benefits directly to the provider for services rendered. ____

I Fully understand that I am responsible for any balance not paid by my insurance company. ____

I authorize the staff to perform any necessary services during diagnosis and treatment. ____

I authorize the staff to release any information required to process my insurance claims. ____

I understand the above information and understand that it is my responsibility to inform the office of any changes regarding my health or account. ____

Signature of financially responsible party_____Date_____

Date of Birth_____ SS#_____Phone #_____

Mailing Address (if different from above)_____

What brings you to the office today?_____

_____

_____

When and how did this condition begin?_____

_____

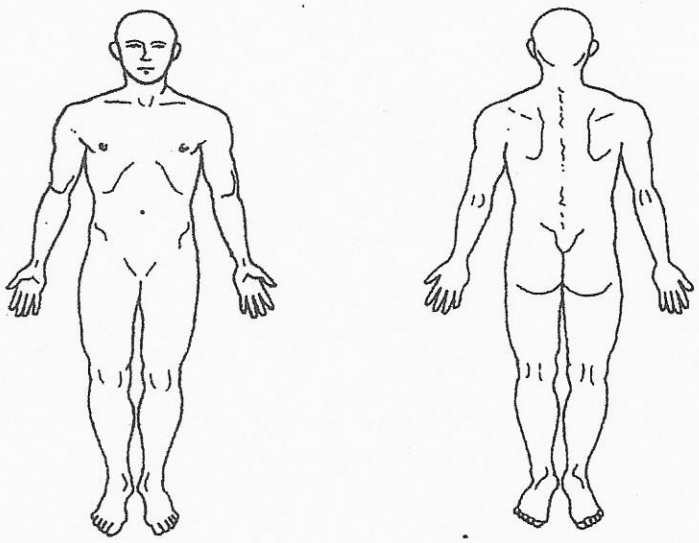
Have you had any treatment of this condition? If so, what treatment was received?

_____

_____

Have you ever seen a chiropractor? If so, who?_____

Mark on the diagram where your pain is located.



On a scale of 0-10 (where 0 is no pain and 10 is the worst pain imaginable), what is your pain level today?_____

Is your pain: _____ Constant _____ Intermittent

Is your pain: (please check all that apply)

___Aching ___Dull ___Throbbing ___Nagging ___Burning ___Sharp

___Stinging ___Tender ___Radiating ___Stabbing Other:_____

What time of the day is your pain worse? (morning, evening, etc.)_____

What makes your pain better? (lying down , standing, ice, heat, etc.)_____

What makes your pain worse? (sitting still, lifting, driving, etc.)_____

Has your pain interfered with any of the following normal activities or emotions?

___Work ___Mood ___Sleep ___Relationship ___Exercise ___Concentration ___Other

Are you taking any of the following medications?

Nerve Pills	Yes/No	Muscle Relaxers	Yes/No
Pain Killers	Yes/No	Stimulants	Yes/No
Insulin	Yes/No	Blood Thinners	Yes/No
Tranquilizers	Yes/No	Please list current medications and dosages:_____	

_____

Who is your medical doctor:_____Phone:_____

Do you have or have you ever had any of the following diseases or conditions?

Yes/No	Heart attack	Yes/No	Emphysema
Yes/No	Stroke	Yes/No	Glaucoma
Yes/No	Congenital heart defect	Yes/No	Psychiatric Problems
Yes/No	Alcohol/drug abuse	Yes/No	Kidney Problems
Yes/No	HIV/AIDS	Yes/No	Sinus Problems
Yes/No	Frequent neck pain	Yes/No	Hepatitis
Yes/No	High/Low blood pressure	Yes/No	Cancer
Yes/No	Severe/ Frequent headaches	Yes/No	Anemia
Yes/No	Fainting/Seizures/Epilepsy	Yes/No	Rheumatic Fever
Yes/No	Diabetes	Yes/No	Ulcers/Colitis
Yes/No	Tuberculosis	Yes/No	Asthma
Yes/No	Heart Surgery/ Pacemaker	Yes/No	Chemotherapy
Yes/No	Mitral Valve Prolapse	Yes/No	Arthritis
Yes/No	Heart Murmur	Yes/No	Artificial Bones/Joints
Yes/No	Artificial Heart Valve	Yes/No	Low Back Problems
Yes/No	Venereal Disease	Yes/No	Difficulty Breathing
Yes/No	Shingles	Other:_____	

Please list anything you may be allergic to:_____

Please list any previous surgeries with dates:_____

_____

Please list any serious accidents or injuries:_____

_____

Do you:

Take vitamins or supplements?		Yes	No	
Observe a special diet?		Yes	No	
Smoke?		Yes	No	If Yes, how much?_____
Wear:	Heel Lifts?	Arch supports?		Inner Soles?

How old is your mattress?_____ Is it comfortable?_____

For Women:

Are you taking birth control?	Yes	No	
Are you Pregnant?	Yes	No	How far along?_____
Are you Nursing?	Yes	No	

Simmons Chiropractic and Wellness Center, P.C.

108 Sterling, Dayton, TX 77535

936-250-5020

_____I give my permission for the doctor and staff at Simmons Chiropractic and Wellness Center, P.C. to use my first and/or last name in the office and when calling by phone.

_____I give my permission for the doctor and staff at Simmons Chiropractic and Wellness Center, P.C. to leave messages on my home and/or mobile phone containing appointment and other treatment related information.

_____

Printed Name

_____

Signature

_____

Date

Privacy Practice Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Date of Birth_____
Today's Date:_____

With whom may we share your Health Information? (ex. Family member, employer, attorney)
Name:_____Relationship to Patient:_____
Address:_____
Phone:_____Date of Birth:_____

Signature of Patient or Guardian_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy,

bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____Date:_____

Parent or Guardian: _____Signature: _____ Date:_____

Witness Name: _____Signature: _____Date:_____