Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Personal Contact Information **Today's Date** _____

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Height _____ Weight _____ Gender at Birth _____

Work Phone _____ Employer _____

Cell Phone _____ Occupation _____

Email _____

Marital Status (circle one): Single Partnered Married Divorced Widowed # of Children _____

Emergency Contact: Name _____ Phone _____

Relationship to Patient _____

Medical History

Do **You** have any history of (Check all that apply):

- ☐ Heart Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Hypertension
- ☐ Low blood sugar
- ☐ Low blood pressure
- ☐ Liver disease
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Concussion
- ☐ Head injury
- ☐ Depression
- ☐ Mental illness
- ☐ Other _____

Elaborate on any **Family** history of the above: _____

Have you ever had any broken bones? ☐ Yes ☐ No

Which bone(s) and when? _____

Any long-term effects? _____

Have you ever had any surgeries? ☐ Yes ☐ No

Please list any surgical procedures and their respective dates: _____

When was your last physical exam? _____

Results: _____

Results of latest lab work? _____

Nutrition and Exercise History

Do you smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No If Yes, Cessation date: _____

Do you drink Alcohol? ☐ Yes ☐ No If Yes, How much and how often? _____

Are you a Vegetarian? ☐ Yes ☐ No If Yes, What kind? _____

How many meals do you eat per day? _____ How often do you eat out? _____

What type of food do you eat when eating out? _____

Do you exercise regularly? ☐ Yes ☐ No If Yes, What kind of exercise and how often? _____

List all medications, vitamins and supplements that you are currently taking: _____

Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

History of Present Illness

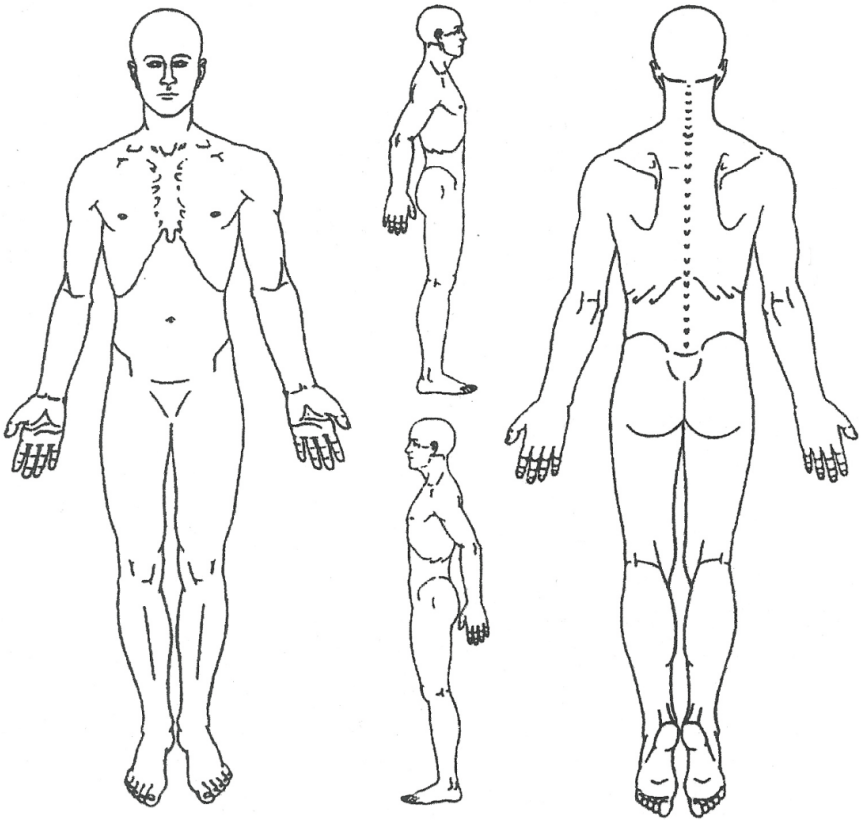
Describe the symptoms that you are experiencing, their location(s), and types of pain: _____

When did you first notice these symptoms? _____

Has this happened before? ☐ Yes ☐ No If Yes, When? _____

Mark the areas where you feel the described sensations on the pictures below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXX	*****	/////



Neck - Shoulder - Arm Pain
On a scale of zero to ten,
I rate my discomfort as follows:

0 ←——————→ 10
No pain Severe pain

Mid Back Pain
On a scale of zero to ten,
I rate my discomfort as follows:

0 ←——————→ 10
No pain Severe pain

Low Back and Leg Pain
On a scale of zero to ten,
I rate my discomfort as follows:

0 ←——————→ 10
No pain Severe pain

Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Was the pain caused by (Check all that apply):

- ☐ Strain, Date of strain _____
- ☐ Fall, Date of fall _____
- ☐ Mental stress
- ☐ Emotional stress
- ☐ Auto accident, Date of accident _____

Is this a work related accident? ☐ Yes ☐ No

We are not a worker's compensation provider under the State of Texas and therefore are unable to treat any work related injuries.

Have you seen another doctor for this? ☐ Yes ☐ No

Name of Doctor: _____ City: _____ X-Rays: _____

Treatment: _____ MRI: _____

Results: _____ CAT Scan: _____

If you have copies of any films or imaging reports that relate to what you are seeking treatment for, please provide these documents to our office.

Are you still under this doctor's care? ☐ Yes ☐ No

When was your last physical? _____ Results: _____

Please list any other information that you feel may be pertinent: _____

How Did You Hear About Us?

- ☐ Another patient — Name of Patient _____
- ☐ Website, Blog — Name of Site _____
- ☐ Social media — Name of Platform _____
- ☐ Other _____

Please read the following statements carefully and sign to indicate your understanding and acceptance of our office policies.

Auto PIP:
We no longer accept assignment on MVA PIP plans. We will provide you a receipt for filing with your insurance company.

Health Insurance:
This office is not under contract with any health insurance plans, therefore we are not able to file your claim or be paid directly by your insurance company. We are considered an “out-of-network” provider on all/most PPO, therefore your insurance company should reimburse you for your treatment up to the allowable percentage after your deductible. You will be responsible for paying your bill in full as services are rendered, and you will be provided an itemized receipt sufficient for your insurance purposes. HMO Plans require that you go to doctors on their list, therefore you will not be reimbursed for your visit here. We accept VISA, MASTERCARD, AMEX, DISCOVER CARD, HSA, FSA & TexFlex Cards for your convenience.

Medicare:
While we do not accept assignment on Medicare and cannot be paid directly by Medicare, we will file your claim to Medicare as a courtesy to you. Medicare should reimburse you for your treatment up to the allowable percentage after your deductible. You will be responsible for paying your bill in full as services are rendered. Please provide us with your Medicare card so we may make a copy of it.

Worker's Comp:
We are no longer a worker's compensation provider under the State of Texas and therefore we are unable to treat any work related injuries until you are released from said worker's comp claim.

Cancellation Policy:
In order to avoid a $85 Missed Appointment Fee, we require a **2 Hour Notice** if you need to cancel your appointment.

Treatment Room Policies:
Only the patient is allowed in the room with the doctor, with the exception of small children or extenuating circumstances requiring the presence of another person. We make those determinations on a case-by-case basis.

In order to better know you and your family, we welcome your child(ren) in our office. However, we find that the nature of our hydraulic equipment poses a safety hazard. Therefore, we ask that you bring someone with you to watch your child(ren) in the waiting area while you are receiving your treatment.

E-Mail/Texting:
As an added convenience, we will text/email patients upon consent/request regarding upcoming appointment reminders, available appointments, supplement shipments, the arrival of test results, etc. Initial below if you **DO NOT** want this form of communication.
I **DO NOT** want text/email communication. _____

HIPAA:
I have been provided a copy of this office's HIPAA policies.

Signature of Patient (or Guardian if under 18 years old)	Relationship to Patient	Today's Date