



221 Regency Parkway, Suite 101

817-453-0430 Fax: 817-453-0400

Mansfield, TX 76063

Phone:

PATIENT INFORMATION Date: _____

Name _____

Address _____

City _____ State _____ Zip _____

Home PH _____ SS# _____

Alt. PH _____

Birth Date ____/____/____ Age ____ Sex ____

OMarried OSingle ODivorced OWidowed

Email _____

Whom may we thank for referring you? _____

EMPLOYMENT INFO

Occupation _____

Employer _____

Address _____

Phone# _____

EMERGENCY INFO

Contact Name _____

Relationship _____

Phone # _____

Previous chiropractic care None

Doctor's name/Date of last visit _____

Previous physical therapy care None

Doctor's name/Date of last visit _____

CURRENT HEALTH CONDITION

CHIEF COMPLAINT: _____

When did symptoms first appear? _____

Has this condition occurred before? Yes No

How often do you experience the symptoms?

Constant 100% Frequent 75%

Intermittent 50% Occasional 25%

Rare 10%

What makes the symptoms worse? _____

What relieves the symptoms? _____

How would you describe the pain?

Sharp Dull Aching Burning Numb

Throbbing Radiating Deep Other

Rate the pain on a scale of 1-10 (10 being unbearable pain)

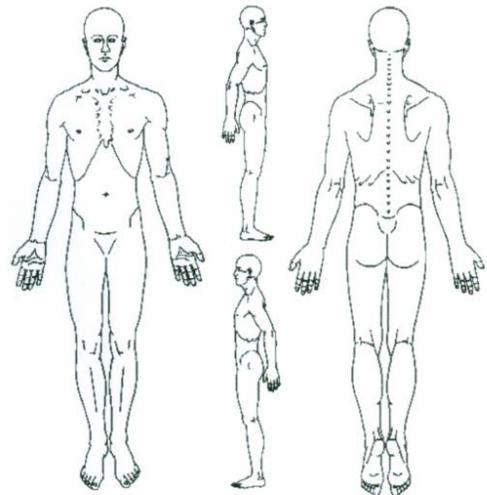
Right now 1---2---3---4---5---6---7---8---9---10

At its worst 1---2---3---4---5---6---7---8---9---10

Other Doctors seen for this condition Yes No

If so, please list the name(s) of physician(s) seen for this condition: _____

Mark your areas of concern



Type of treatment? _____ Results _____

Is this condition: Job related Auto Accident Home Injury Fall Other _____

Do you wear a shoe lift? Yes No

Do you suffer from any condition other than which you are now consulting us? Yes (explain) No

Are you in litigation for any accidents (Auto, Workmens Comp. Etc.) at this time? Yes No

Female Patient: Is there any possibility you are pregnant? Yes No

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

- | | | | | |
|-----------------------------------|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever |

CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS

Musculoskeletal Code

- General Stiffness
- General Weakness
- Swollen Joints
- Spinal Curvature
- Neck Pain
- Arm Pain

General Code

- Fatigue/Weakness
- Allergies
- Headaches
- Loss of Sleep
- Weight Change
- Fever/Chills

C-V-R Code

- Chest Pain
- Short Breath
- Asthma
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems

Genitourinary Code

- OBladder Trouble
- OPainful/Excessive Urine
- ODiscolored Urine

Nervous System Code

- Nervous
- Numbness
- Dizziness
- Forgetfulness
- Depression
- Cold/Tingling in extremities
- Stress
- Twitching
- Other Endocrine problems
- Change in sex characteristics
- Neck/Surgery/Irradiation
- Diabetes

Gastrointestinal Code

- Poor/Excessive Appetite
- Excessive Thirst
- Vomiting
- Nausea
- Diarrhea
- Constipation
- Liver Problems
- Gall Bladder Problems
- Abdominal Cramps
- Gas/Bloating/Belching
- Heartburn
- Black/Bloody/Stools

EENT Code

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose
- Frequent Colds
- Nose Bleeds
- Sinus Trouble
- Hoarseness

Family History

- The following members have the same or similar problem(s) as I do:
- Father
 - Mother
 - Brother
 - Sister
 - Other _____

For Women Only

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Pain b/w shoulders | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Height Change | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Irregular Cycle |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Sweats | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Painful Periods |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Bleeding/Bruising | <input type="checkbox"/> Stroke | <input type="checkbox"/> Pregnant (now) |
| <input type="checkbox"/> Jaw Problems | | | |
| <input type="checkbox"/> Heat & Cold Intolerance | | | |

OCCUPATIONAL INFORMATION

Job involves Sitting Standing How long? _____

Bending Stooping Twisting Turning Lifting – How much weight _____

Physical activity at work: Sedentary Light manual labor Heavy Labor

Telephone use at work None Moderate Heavy Traditional receiver Headset

Do any work activities aggravate your complaints? _____

HEALTH HABITS

Exercise/Sports/Hobbies:

1) Type _____ Frequency _____ 2) Type _____ Frequency _____

3) Type _____ Frequency _____ 4) Type _____ Frequency _____

Sleep:

Hours/Night _____ Sleep Quality _____

Do you sleep on your: Back Side Stomach

Smoking/Drinking/Diet: (how much and how often)

Tea/Coffee _____ Liquor/Beer _____ Cigarettes/Tobacco _____

HEALTH HISTORY

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

Please list ALL previous accidents and falls

What _____ When _____

What _____ When _____

What _____ When _____

Please list ALL medications and / or vitamins you take

Name _____ For What _____ Name _____ For What _____

Name _____ For What _____ Name _____ For What _____

Name _____ For What _____ Name _____ For What _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Check here if you want the doctor to select the type of care appropriate for your condition.

METHOD OF PAYMENT

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

Patient General Questionnaire

Patient Name: _____

DOB: _____

Do you have any of the following conditions?

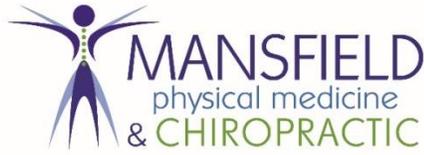
	Yes	No		Yes	No
Implanted Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to latex	<input type="checkbox"/>	<input type="checkbox"/>
Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Are you under treatment for any Acute medical condition	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Are you suffering from any chronic muscle or nerve disorder other than currently being treated	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Legal Guardian Signature

Date

Patient Comments: _____



24 Hour Cancellation Policy

This cancellation policy is standard in the medical field and will be strictly enforced.

On occasion, there will be understandable reasons for missing an appointment. However, when you are able to notify us of your intention to cancel/reschedule with **24 HOURS IN ADVANCE**, it gives us an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list or may also be looking for an opportunity to reschedule for a different time. Therefore, as much advance notice as possible is always appreciated.

IF YOU CANCEL YOUR APPOINTMENT WITH LESS THAN 24 HOURS NOTICE OR SIMPLY DO NOT SHOW UP, YOU WILL BE CHARGED \$25.00 FOR THE MISSED APPOINTMENT.

Because it is illegal to bill your insurance company for a missed appointment, you will end up paying the full fee out-of-pocket, resulting in a much higher payment than you may have paid for a kept appointment. For many, this creates an unnecessary hardship. In addition, it is possible that your therapy would be suspended until the fee is paid.

Arriving late without notification: We will wait 15 minutes, after which we will assume you are not going to make your appointment. In such a case, you will be charged for the missed appointment.

OFFICE PHONE NUMBER: 817.453.0430

Please make any cancellations less than 24 hours in advance by using this telephone number. If less than 24 hours please do not cancel by email or by any other means than by this phone number. This cancellation number is also plainly available on the front of the business card.

Please sign below to indicate you have read, understand, and agree to abide by the cancellation policy.

Print Patient Name

Date

Signature of Patient



HIPAA PRIVACY NOTIFICATION & PRACTICE REQUIREMENTS

Mansfield Physical Medicine and Rehabilitation Center:

- (a) Is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
- (b) Under the Privacy Rule, (the practice) may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- (c) Is required to abide by the terms of the Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.
- (g) Will provide to you, for your convenience, the office's HIPPA Compliance book upon request.
- (h) Additionally, the Patient Rights & Responsibilities document explains the Office's responsibilities toward the patient and the patient's toward the office. Every patient will be given this document for review at their leisure.

EFFECTIVE DATE:

This Notice is in effect as of 01/01/2017.

PATIENT ACKNOWLEDGEMENT:

By subscribing my name below, I acknowledge having read the Notice; I understand it and agree to its terms.

Print Patient Name

Date

Signature of Patient

Informed Consent to Treat

- **The nature of the chiropractic adjustment.**

I will use my hands or a mechanical instrument, upon your body, in such a way, as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel or sense a movement of the joint. Some patients will feel some stiffness and soreness following the first few days of treatment.

- **The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations and rib fractures. In extremely rare instances, some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

- **The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during the examination. Stroke has been the subject of tremendous disagreement within the medical community. One prominent authority claims that there is at most a one-in-a-million chance of such an outcome. As a policy, to reduce your risk, 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."

- **Ancillary (Modality) treatment.**

In addition to chiropractic adjustments, I intend to use the following treatments which have been listed with their known risks:

- *Electrical stimulation* – Skin burns. Our equipment monitors stimulation levels to avoid this from happening.
- *Ultrasound therapy* – burning of periosteum of bone and soft tissues
- *Low Level Laser Light Therapy* – only used when not contraindicated. There are no known risks with the levels of light that we use.
- *Physiotherapy* – used to rehabilitate muscles, ligaments and nerves. Possible side effects are:
 - Muscle strain and/or reinjury of presented complaint(s)
 - Ligamentous strain, sprain or reinjury
 - Possible reinjury of presented complaint(s)
- *Manual therapy* – used to release muscle tension, skeletal subluxation and toxins. This can cause muscle stiffness and aches as well as headaches and/or bruising of the soft tissues. Drinking plenty of water should aid in a quick recovery if these symptoms arise.

- **The availability and nature of other treatment options.**

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest or exercise, etc.
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers, etc.
- Hospitalization with traction
- Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**

- Overuse of over-the-counter medications can produce 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 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 painkillers 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 pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
- Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; 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 induced) mishap, all those of hospitalization 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. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

- **Treatment Outcome Possibilities**

The treatment provided in this clinic has proven to be effective in treating a variety of illnesses and health problems. The outcome of treatments provided have the following possibilities: the symptoms or illness you have sought care for may improve, may remain unchanged, or have the possibility of getting worse. We strive to ensure that your care is complete and that you will be satisfied with your outcome.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. I have read or have had someone read to me the above explanation of the chiropractic adjustment and related treatments and possible risks with undergoing/receiving chiropractic and physiotherapy treatment and in not receiving such treatment. By signing below, I state that I have weighed the risks involved in undergoing/receiving Chiropractic Treatment and all rehabilitation therapy and I have decided that it is in my best interest to undergo/receive chiropractic treatment as well as all other treatments and services offered and provided by Mansfield Physical Medicine and Rehabilitation Center. Having been informed of the risks, I hereby give my consent to any and all treatment deemed necessary for any reason. I understand that if I have any questions regarding treatment or services, I may ask the doctor or staff at any time.

Print Patient Name

Date

Signature of Patient