

CASE HISTORY

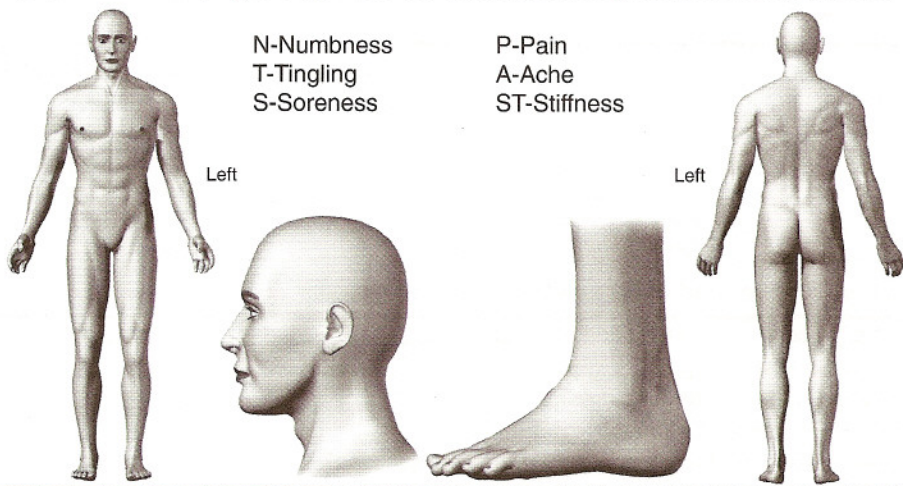
Name: _____ Age: _____ Date: _____ Case Number: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone:(H) _____ (C) _____ Fax: _____ E-mail: _____
 Date of Birth: _____ Sex: M F Marital Status: S M D W # of Children: _____
 Occupation: _____ Employer: _____ Telephone (Work): _____ Ext. _____
 Insured's Name: _____ Phone: _____ Insured's Date of Birth: _____
 Spouse's Name: _____ Spouse's Occupation: _____
 Spouse's Employer: _____ Spouse's Telephone (Work): _____
 Past Chiropractic Care: Yes No When? _____ Doctor's Name: _____
 Results: _____
 Insurance Company: _____ Telephone: _____
 Social Security Number: _____ Driver's License Number: _____ State: _____
 Spouse's Insurance Company: _____ Telephone: _____
 Spouse's Social Security Number: _____ Spouse's Driver's License Number: _____
 Emergency Contact: _____ Relationship _____ Contact Number _____

Are your present problems due to an injury? No Yes On the Job Auto Accident Personal Injury Other: _____
 Has the accident been reported? No Yes To Employer Auto Carrier Other: _____
 Are you now or have you ever been disabled? (Service or Work)? No Yes When? _____ Why? _____
 Have you retained an attorney? No Yes Name & Address: _____

Pain Symptoms: 1. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 (in order of 2. _____ Began-(Mo/Yr): _____ Previous Episodes: _____
 severity) 3. _____ Began-(Mo/Yr): _____ Previous Episodes: _____

Please mark the intensity of your pain today.
 0 - NO PAIN
 10 - INTENSE PAIN
 Example _____ Neck
 O 1 2 3 ④ 5 6 7 8 9 10
 1. _____
 O 1 2 3 4 5 6 7 8 9 10
 2. _____
 O 1 2 3 4 5 6 7 8 9 10
 3. _____
 O 1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below.



DOCTORS USE ONLY

HABITS

Smoking Packs/Day: _____
 Drinking Alcohol: _____
 Caffeine Cups/Day: _____

EXERCISE

None
 Light Activity
 Moderate Activity
 Active
 Very Active
 Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, # of: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

<input type="checkbox"/> 541 Appendicitis	<input type="checkbox"/> 280 Anemia	<input type="checkbox"/> 429.9 Heart Disease	<input type="checkbox"/> 716 Arthritis
<input type="checkbox"/> 480 Pneumonia	<input type="checkbox"/> 055 Measles	<input type="checkbox"/> 240 Goiter	<input type="checkbox"/> 345 Epilepsy
<input type="checkbox"/> 390 Rheumatic Fever	<input type="checkbox"/> 072 Mumps	<input type="checkbox"/> 487 Influenza	<input type="checkbox"/> 319 Mental Disorder
<input type="checkbox"/> 045 Polio	<input type="checkbox"/> 052 Chicken Pox	<input type="checkbox"/> 511 Pleurisy	<input type="checkbox"/> 724.2 Lumbago
<input type="checkbox"/> 011 Tuberculosis	<input type="checkbox"/> 250 Diabetes	<input type="checkbox"/> 303.9 Alcoholism	<input type="checkbox"/> 690 Eczema
<input type="checkbox"/> 033 Whooping Cough	<input type="checkbox"/> 239 Cancer	<input type="checkbox"/> 099 Venereal Disease	<input type="checkbox"/> 042 HIV Positive
<input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> 346.9 Migraine Headaches	<input type="checkbox"/> 054.9 Herpes	<input type="checkbox"/> 340 Multiple Sclerosis

(OVER)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. Never Previously Presently.

<table border="0"> <tr> <td style="text-align: center;">Never Previously Presently</td> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>	Never Previously Presently	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<table border="0"> <tr> <td style="text-align: center;">GENERAL SYMPTOMS</td> </tr> <tr> <td>995.3 Allergy (What)_____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 490 Bronchitis</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.9 Chills</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.39 Convulsions</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.4 Dizziness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.2 Fainting</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.79 Fatigue</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.6 Fever</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.0 Headache</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.52 Loss of Sleep</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783 Loss of Weight</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 799.2 Nervousness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 729.2 Neuralgia</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.8 Sweats</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.07 Wheezing</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 311 Depression</td> </tr> </table>	GENERAL SYMPTOMS	995.3 Allergy (What)_____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 490 Bronchitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.9 Chills	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.39 Convulsions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.4 Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.2 Fainting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.79 Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.6 Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.0 Headache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.52 Loss of Sleep	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783 Loss of Weight	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 799.2 Nervousness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 729.2 Neuralgia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.8 Sweats	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.07 Wheezing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 311 Depression	<table border="0"> <tr> <td style="text-align: center;">GASTRO-INTESTINAL</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.3 Belching/Gas/Bloating</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 789.0 Abdominal Pain</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 564.0 Constipation</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.91 Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.6 Excessive Eating</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 575.9 Gall Bladder Trouble</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 455 Hemorrhoids (piles)</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.4 Jaundice</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 794.8 Liver Trouble</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.02 Nausea</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.9 Stomach Pain</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.0 Poor Appetite</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.8 Poor Digestion</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.03 Vomiting</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 578.0 Vomiting Blood</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.5 Excessive Thirst</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.8 Indigestion</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 569.3 Rectal Bleeding</td> </tr> </table>	GASTRO-INTESTINAL	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.3 Belching/Gas/Bloating	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 789.0 Abdominal Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 564.0 Constipation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.91 Diarrhea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.6 Excessive Eating	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 575.9 Gall Bladder Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 455 Hemorrhoids (piles)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.4 Jaundice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 794.8 Liver Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.02 Nausea	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.9 Stomach Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.0 Poor Appetite	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.8 Poor Digestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.03 Vomiting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 578.0 Vomiting Blood	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.5 Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.8 Indigestion	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 569.3 Rectal Bleeding	<table border="0"> <tr> <td style="text-align: center;">EYE/EAR/NOISE/THROAT</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 493.9 Asthma</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 378.9 Crossed Eyes</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 389.9 Deafness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.70 Earache</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.60 Ear Discharge</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.30 Ear Noises</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 240.9 Enlarged Thyroid</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 460 Frequent Colds</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 477 Hay Fever</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.49 Hoarseness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 478.1 Nasal Obstruction</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.7 Nosebleeds</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 379.91 Pain in Eyes</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 368.9 Poor Vision</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 461.9 Sinusitis</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 462 Sore Throat</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 463 Tonsillitis</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.2 Persistent Cough</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.2 Difficulty Swallowing</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 523.8 Bleeding Gums</td> </tr> </table>	EYE/EAR/NOISE/THROAT	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 378.9 Crossed Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 389.9 Deafness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.70 Earache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.60 Ear Discharge	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.30 Ear Noises	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 240.9 Enlarged Thyroid	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 460 Frequent Colds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 477 Hay Fever	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.49 Hoarseness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 478.1 Nasal Obstruction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.7 Nosebleeds	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 379.91 Pain in Eyes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 368.9 Poor Vision	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 461.9 Sinusitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 462 Sore Throat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 463 Tonsillitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.2 Persistent Cough	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.2 Difficulty Swallowing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 523.8 Bleeding Gums	<table border="0"> <tr> <td style="text-align: center;">RESPIRATORY</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.50 Chest Pain</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.2 Chronic Cough</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.09 Difficulty Breathing</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.3 Spitting Blood</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.4 Spitting Phlegm</td> </tr> </table>	RESPIRATORY	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.50 Chest Pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.2 Chronic Cough	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.09 Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.3 Spitting Blood	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.4 Spitting Phlegm
Never Previously Presently	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																																				
GENERAL SYMPTOMS																																																																					
995.3 Allergy (What)_____																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 490 Bronchitis																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.9 Chills																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.39 Convulsions																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.4 Dizziness																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.2 Fainting																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.79 Fatigue																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.6 Fever																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.0 Headache																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.52 Loss of Sleep																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783 Loss of Weight																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 799.2 Nervousness																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 729.2 Neuralgia																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 780.8 Sweats																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.07 Wheezing																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 311 Depression																																																																					
GASTRO-INTESTINAL																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.3 Belching/Gas/Bloating																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 789.0 Abdominal Pain																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 564.0 Constipation																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.91 Diarrhea																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.6 Excessive Eating																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 575.9 Gall Bladder Trouble																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 455 Hemorrhoids (piles)																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.4 Jaundice																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 794.8 Liver Trouble																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.02 Nausea																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.9 Stomach Pain																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.0 Poor Appetite																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.8 Poor Digestion																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.03 Vomiting																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 578.0 Vomiting Blood																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 783.5 Excessive Thirst																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 536.8 Indigestion																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 569.3 Rectal Bleeding																																																																					
EYE/EAR/NOISE/THROAT																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 493.9 Asthma																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 378.9 Crossed Eyes																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 389.9 Deafness																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.70 Earache																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.60 Ear Discharge																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 388.30 Ear Noises																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 240.9 Enlarged Thyroid																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 460 Frequent Colds																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 477 Hay Fever																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.49 Hoarseness																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 478.1 Nasal Obstruction																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 784.7 Nosebleeds																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 379.91 Pain in Eyes																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 368.9 Poor Vision																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 461.9 Sinusitis																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 462 Sore Throat																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 463 Tonsillitis																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.2 Persistent Cough																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 787.2 Difficulty Swallowing																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 523.8 Bleeding Gums																																																																					
RESPIRATORY																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.50 Chest Pain																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.2 Chronic Cough																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.09 Difficulty Breathing																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.3 Spitting Blood																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.4 Spitting Phlegm																																																																					
			<table border="0"> <tr> <td style="text-align: center;">GENITO-URINARY</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.36 Bed Wetting</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 599.7 Blood in Urine</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.4 Frequent Urination</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.3 Lack of Bladder Control</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 590.9 Kidney Infection</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.1 Painful Urination</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 601.9 Prostate Trouble</td> </tr> </table>	GENITO-URINARY	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.36 Bed Wetting	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 599.7 Blood in Urine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.4 Frequent Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.3 Lack of Bladder Control	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 590.9 Kidney Infection	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.1 Painful Urination	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 601.9 Prostate Trouble																																																										
GENITO-URINARY																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.36 Bed Wetting																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 599.7 Blood in Urine																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.4 Frequent Urination																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.3 Lack of Bladder Control																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 590.9 Kidney Infection																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 788.1 Painful Urination																																																																					
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 601.9 Prostate Trouble																																																																					

<table border="0"> <tr> <td style="text-align: center;">MUSCLES/JOINTS/BONES</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 724.5 Backache</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.7 Foot Trouble</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 550 Hernia</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.1 Pain Between Shoulders</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 724.6 Painful Tail Bone</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 723.9 Stiff Neck</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.9 Spinal Curvature</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.0 Swollen Joints</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.0 Tremors/Twitching</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782 Arm Trouble</td> </tr> </table>	MUSCLES/JOINTS/BONES	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 724.5 Backache	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.7 Foot Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 550 Hernia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.1 Pain Between Shoulders	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 724.6 Painful Tail Bone	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 723.9 Stiff Neck	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.9 Spinal Curvature	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.0 Swollen Joints	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.0 Tremors/Twitching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782 Arm Trouble	<table border="0"> <tr> <td style="text-align: center;">CARDIO-VASCULAR</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 401.9 High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 458.9 Low Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.51 Pain Over Heart</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 785.9 Poor Circulation</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 438 Previous Heart Trouble</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 785.0 Rapid Heart</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 427.89 Slow Heart</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 436 Strokes</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.7 Swelling Ankles</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 454 Varicose Veins</td> </tr> </table>	CARDIO-VASCULAR	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 401.9 High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 458.9 Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.51 Pain Over Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 785.9 Poor Circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 438 Previous Heart Trouble	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 785.0 Rapid Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 427.89 Slow Heart	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 436 Strokes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.7 Swelling Ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 454 Varicose Veins	<table border="0"> <tr> <td style="text-align: center;">SKIN OR ALLERGIES</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 680.9 Boils</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 924.9 Bruising Easily</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 701.1 Dryness</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 691.8 Eczema</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 708.9 Hives or Allergy</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 698.9 Itching</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.0 Sensitive Skin</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.1 Skin Eruptions</td> </tr> </table>	SKIN OR ALLERGIES	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 680.9 Boils	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 924.9 Bruising Easily	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 701.1 Dryness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 691.8 Eczema	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 708.9 Hives or Allergy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 698.9 Itching	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.0 Sensitive Skin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.1 Skin Eruptions	<table border="0"> <tr> <td style="text-align: center;">FOR WOMEN ONLY</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 625.3 Cramps or Backaches</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 626.2 Excessive Flow</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 627.2 Hot Flashes</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 626.4 Irregular Cycle</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 634.9 Miscarriage</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 625.3 Painful Periods</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 623.5 Vaginal Discharge</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 611.79 Lump in Breast</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this time?</td> </tr> <tr> <td><input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a mammogram?</td> </tr> <tr> <td>_____ Last Pap Smear Date</td> </tr> <tr> <td>_____ By Whom</td> </tr> </table>	FOR WOMEN ONLY	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 625.3 Cramps or Backaches	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 626.2 Excessive Flow	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 627.2 Hot Flashes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 626.4 Irregular Cycle	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 634.9 Miscarriage	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 625.3 Painful Periods	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 623.5 Vaginal Discharge	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 611.79 Lump in Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a mammogram?	_____ Last Pap Smear Date	_____ By Whom
MUSCLES/JOINTS/BONES																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 724.5 Backache																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.7 Foot Trouble																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 550 Hernia																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.1 Pain Between Shoulders																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 724.6 Painful Tail Bone																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 723.9 Stiff Neck																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.9 Spinal Curvature																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.0 Swollen Joints																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 781.0 Tremors/Twitching																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782 Arm Trouble																																															
CARDIO-VASCULAR																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 401.9 High Blood Pressure																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 458.9 Low Blood Pressure																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 786.51 Pain Over Heart																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 785.9 Poor Circulation																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 438 Previous Heart Trouble																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 785.0 Rapid Heart																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 427.89 Slow Heart																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 436 Strokes																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 719.7 Swelling Ankles																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 454 Varicose Veins																																															
SKIN OR ALLERGIES																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 680.9 Boils																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 924.9 Bruising Easily																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 701.1 Dryness																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 691.8 Eczema																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 708.9 Hives or Allergy																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 698.9 Itching																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.0 Sensitive Skin																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 782.1 Skin Eruptions																																															
FOR WOMEN ONLY																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 625.3 Cramps or Backaches																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 626.2 Excessive Flow																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 627.2 Hot Flashes																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 626.4 Irregular Cycle																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 634.9 Miscarriage																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 625.3 Painful Periods																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 623.5 Vaginal Discharge																																															
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 611.79 Lump in Breast																																															
<input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant at this time?																																															
<input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a mammogram?																																															
_____ Last Pap Smear Date																																															
_____ By Whom																																															

OPERATIONS AND PROCEDURES																																
<table border="0"> <tr> <td style="text-align: center;">DATE</td> <td>Vaccinations</td> </tr> <tr> <td>_____</td> <td>Tonsillectomy</td> </tr> <tr> <td>_____</td> <td>Gall Bladder</td> </tr> <tr> <td>_____</td> <td>Back Operation</td> </tr> <tr> <td>_____</td> <td>Other: _____</td> </tr> </table>	DATE	Vaccinations	_____	Tonsillectomy	_____	Gall Bladder	_____	Back Operation	_____	Other: _____	<table border="0"> <tr> <td style="text-align: center;">DATE</td> <td>Tubes in Ears</td> </tr> <tr> <td>_____</td> <td>Appendectomy</td> </tr> <tr> <td>_____</td> <td>Female Organs</td> </tr> <tr> <td>_____</td> <td>Rectal Surgery</td> </tr> <tr> <td>_____</td> <td>Other: _____</td> </tr> </table>	DATE	Tubes in Ears	_____	Appendectomy	_____	Female Organs	_____	Rectal Surgery	_____	Other: _____	<table border="0"> <tr> <td style="text-align: center;">DATE</td> <td>Sinus</td> </tr> <tr> <td>_____</td> <td>Hernia</td> </tr> <tr> <td>_____</td> <td>Thyroid</td> </tr> <tr> <td>_____</td> <td>Stomach</td> </tr> <tr> <td>_____</td> <td>Other: _____</td> </tr> </table>	DATE	Sinus	_____	Hernia	_____	Thyroid	_____	Stomach	_____	Other: _____
DATE	Vaccinations																															
_____	Tonsillectomy																															
_____	Gall Bladder																															
_____	Back Operation																															
_____	Other: _____																															
DATE	Tubes in Ears																															
_____	Appendectomy																															
_____	Female Organs																															
_____	Rectal Surgery																															
_____	Other: _____																															
DATE	Sinus																															
_____	Hernia																															
_____	Thyroid																															
_____	Stomach																															
_____	Other: _____																															

I have never had any operations / surgeries

List any accidents or falls and dates: Car: _____ Recreation: _____
 Sports: _____ School: _____ Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? Yes No Why? _____

Have you ever had any spinal taps or spinal injections? Yes No Were you ever knocked unconscious? Yes No

Have you ever had a lapse of memory? Yes No

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over-the-counter? Yes No What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X _____ Date: _____

A & M Chiropractic
4012 S.W. Green Oaks Blvd.
Arlington, TX 76017
817-572-0072

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Date: _____

Signature: _____

PATIENT QUESTIONNAIRE

- I. Please list the family members or significant others, if any whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations):

Name _____ Phone _____

Emergency contact _____ Phone _____

- II. We will be contacting you regarding appointment reminders and other non-medical calls. If you have another contact number, other than, the one previously listed, please provide.

Phone _____

Patient Name _____ (guardian if under 18)

SIGNATURE

DATE

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND
ADJUNCTIVE CARE

As a patient in my office, you have the legal right to know the complications/side-effects associated with treatment.

This form is intended to inform you of these, and treatment will not be given until you understand these issues and signify your consent by signing this form.

The Material Risks Inherent in a Chiropractic Adjustment: Serious **complications to chiropractic treatment are rare**, however, these may include fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some patients will feel some stiffness or soreness following the first few days of treatment, they may even experience a worsening of their symptoms for a short period of time, which is considered part of the normal healing process.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. IF YOU HAVE UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at this time, based upon the facts then known, is in my best interest.

I hereby request and consent to the performance of chiropractic adjustments and other complimentary procedures, including various modes of physical therapy and diagnostic x-rays, for me, (or on the patient named below for whom I am legally responsible) by A&M Chiropractic and /or affiliated associates who now or in the future treat me while employed by, working or associated with this office. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read () or have had read to me () the above explanation of the chiropractic care and related treatments. I have discussed it with the doctor and/or staff of this office and have had my questions answered to my satisfaction. By signing below, I state that I have considered the risk involved in the proposed treatment. Having been informed of the nature of the risks of chiropractic care, I hereby give my consent to be treated. I intend for this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Name: _____ Dated: _____

Signature: _____ Witness: _____

A&M Chiropractic

P.O. Box 170156
Arlington, Texas 76003

ASSIGNMENT

_____, SS# _____
("Assignor") is the obligor and/or will be the obligor of certain sums for medical services that are now due and/or are to become due from _____

("Obligor") pursuant to terms of an Agreement by and between Obligor and Dr. Andrea Milne d/b/a A&M Chiropractic, after performance of Dr. Milne's medical services as stated in the Agreement referred to above.

FOR VALUABLE CONSIDERATION, Assignor hereby assigns, transfers and conveys any and all right, title and interest in and to the cause-of-action and settlement proceeds, judgment or recovery thereon arising under and/or from Assignor's claims originating from assignor's _____(Date) moving vehicle accident with _____("Claim Proceeds) to *Dr. Andrea Milne, d/b/a A&M Chiropractic ("Assignee"), of P.O Box 170156, Arlington, TX 76003-0156, To the extent of Assignor's outstanding account balance with Dr. Milne.*

This assignment covers all the Claim Proceeds that are now due and payable and/or shall become due and payable to the Assignor's agents. Assignor hereby authorizes the direct payment of any and all claim proceeds to Assignee to the extent of Assignor's outstanding account balance with Assignee.

This assignment is irrevocable and shall remain in full force and effect until all monies owed by Assignor to Dr. Andrea Milne d/b/a/ A&M Chiropractic are paid in full.

IN WITNESS WHEREOF, Assignor has executed this Assignment on _____

Assignor

Dr. Andrea Milne, Assignee

AUTHORIZATION TO ENDORSE CHECKS

- ❖ Whereas the undersigned has or will have incurred certain obligations or expenses for chiropractic services rendered by the clinic and /or doctor named below;
- ❖ Whereas the undersigned may be entitled to receive compensation for said obligations or expenses from Blue Cross/Blue Shield or other insurance carriers;
- ❖ Now therefore, the undersigned hereby specifically authorizes A&M Chiropractic and /or the doctor to receive any insurance company checks in payment of the aforesaid services and to endorse, deposit and negotiate said checks in payment of the undersigned obligations to this clinic and/or doctor.
- ❖ This authorization shall remain valid unless and until revoked in writing by the undersigned. Any person to whom this authorization is presented may rely upon the written statements of this doctor to the effect that the same has not been revoked.

**A&M Chiropractic
P.O. Box 170156
Arlington, TX 76003-0156**

BY: _____ BY: _____ Date: _____
Patient Witness

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking care of 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 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 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 data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in Texas.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed, _____ are paid in full.

BY: _____ Date: _____
Patient's Signature

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ To _____.

BY: _____ BY: _____ Date: _____
Patient Witness

CONSENT TO X-RAY

I hereby authorize A&M Chiropractic and whomever the Clinician may designate as the doctor's assistant(s) to take x-rays needed for diagnosis and treatment.

BY: _____ BY: _____ Date: _____
Patient Witness

FOR FEMALES ONLY

This section must be completed by all females of childbearing age and signed in the patient's own handwriting.
First day of last menstrual period: _____

I hereby release A&M Chiropractic from any and all liabilities. I also hereby declare that, to my knowledge, I am not pregnant.

BY: _____ BY: _____ Date: _____
Patient Witness

LETTER OF NO
ACCIDENT OR INJURY

I _____ hereby state with my signature that I was not involved in any auto accident, slip and fall, or work injury. My treatment is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment.

Please process and pay all claims immediately.

Sincerely,

Patient Signature

Date

Important Insurance Verification Notification

As a courtesy to our patients, we will call your insurance company to verify your benefits and coverage with our clinic. The information obtained by us from the Insurance Carrier is to the best of our knowledge reliable; but not guaranteed.

It is the patients responsibility to confirm and verify coverage between any provider and your insurance company. Any services not covered or paid for by your insurance company will be the responsibility of the patient or parent/guardian of the patient.

I have read the above statement and accept responsibility for payment of any and all services provided by A&M Chiropractic, P.C. should my insurance company not cover or deny a service or charge for any reason.

Patient Printed Name: _____

Parent / Guardian Printed Name: _____

Patient/Parent/Guardian Signature: _____

Date: _____

Witness: _____ Date: _____

AUTHORIZATION TO TREAT A MINOR

A & M Chiropractic
4012 S.W. Green Oaks Blvd
Arlington, Texas 76017
817-572-0072 phone

DATE: _____

This is to certify that A&M Chiropractic has my permission to administer chiropractic care as deemed necessary to my child or dependant,

Minor's Name

Parent or Legal Guardian

Witness

Treating Doctor