Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:__ARNOLD**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: ☐M ☐S ☐W ☐D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto☐ Work☐ Other☐_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

☐Broken or Fractured Bones	☐Osteoarthritis	☐Eating Disorder
☐Circulatory Problems	☐Epilepsy	☐Alcoholism
☐Rheumatoid Arthritis	☐Pace Maker	☐Drug Addiction
☐Seizures/Convulsions	☐Diabetes	☐HIV Positive
☐A Congenital Disease	☐Cancer	☐Gall Bladder
☐Excessive Bleeding	☐Ruptures	☐Depression
☐Low Blood Pressure	☐Coughing Blood	☐Ulcers

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ☐Yes ☐No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐Yes ☐No

If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____
_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents:
Father: living☐ deceased☐ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Mother: living☐ deceased☐ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Check if applicable to you: ☐ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	High Blood Pressure____

Other _____

Please check any and all insurance coverage that may be applicable in this case**:**
☐Major Medical ☐Medicaid ☐Medicare ☐Auto Accident
☐Medical Savings Account & Flex Plans ☐Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____
AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Steven V. Arnold, DC or Arnold Chiropractic Center, LLC. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient Name:_____ Date:_____ Patient Number:_____

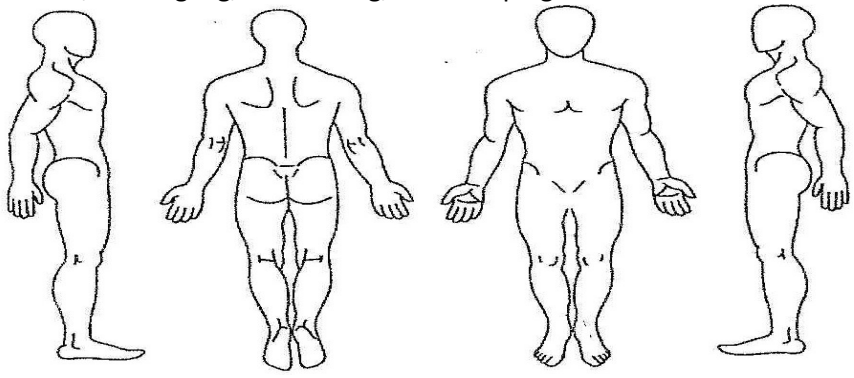
Complaint History

Complaint 1:
When did your complaint first begin? _____ or approximately _____ Weeks/Months/Years Ago
Have you ever experienced this complaint before? _____ When? _____
What makes the problem better? _____
What makes the problem worse? _____
Describe the type of pain/symptom you experience? _____
Does your problem travel into any other part of the body? ____ Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc…)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? ____

Complaint 2:
When did your complaint first begin? _____ or approximately _____ Weeks/Months/Years Ago
Have you ever experienced this complaint before? _____ When? _____
What makes the problem better? _____
What makes the problem worse? _____
Describe the type of pain/symptom you experience? _____
Does your problem travel into any other part of the body? ____ Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc…)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? ____

Complaint 3:
When did your complaint first begin? _____ or approximately _____ Weeks/Months/Years Ago
Have you ever experienced this complaint before? _____ When? _____
What makes the problem better? _____
What makes the problem worse? _____
Describe the type of pain/symptom you experience? _____
Does your problem travel into any other part of the body? ____ Where? _____
_____
Where exactly is the complaint area? _____
When do you notice the problem? _____
Have you lost control of any body part (arms, legs, bladder, bowel, etc…)? _____
Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? ____

Please mark off the area of you complaint on diagram below. Use the following symbols:
P = Pain, N = Numbness, T = Tingling, B = Burning, C = Cramping



INFORMED CONSENT

PATIENT NAME _____

Clinic Name: Arnold Chiropractic Center, LLC

Doctor's Name: Steven V. Arnold, D.C., FIAMA

Address: 25802 Interstate 45, Suite A, Spring, Texas 77386

Phone: 936-321-9900 Fax: 281-419-9901

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect that would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Arnold Chiropractic

RESCHEDULING, NO SHOW AND LATE CANCELLATION POLICY

YOUR APPOINTMENT IS TIME SET ASIDE ESPECIALLY FOR YOU. NO-SHOW APPOINTMENTS REPRESENT A COST TO US, TO YOU, AND TO OTHER PATIENTS WHO COULD HAVE BEEN SEEN IN THE TIME RESERVED FOR YOU.

IF YOU MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT, PLEASE CALL OUR OFFICE TO INFORM US AT LEAST 4 HOURS PRIOR TO YOUR APPOINTMENT. PLEASE BE NOTIFIED THAT IF THE REQUIRED NOTICE IS NOT GIVEN, A $50.00 FEE WILL BE CHARGED TO YOU AND IS IMMEDIATELY PAYABLE. THIS FEE IS NOT COVERED BY INSURANCE

EXCESS ABUSE OF THIS POLICY WILL RESULT IN DISCHARGE FROM THIS PRACTICE.

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Signature Date

25802 INTERSTATE 45 N., SUITE A • SPRING, TEXAS • 77386
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