

Confidential Client History for Texas Family Wellness

Personal History

Date: / /

File #

Name _____
 Birth Date _____ Age _____ Sex _____
 Address: _____
 City: _____
 State: _____ Zip Code: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 E-mail: _____

Single Married Separated Divorced Widowed
 Name of Spouse _____
 No. of Children: _____ Ages: _____
 Names: _____

 Employer: _____
 Type of Work: _____
 Who is responsible for your bill: Self or Other
Referred to this office by: _____

Please check the appropriate for any of the following symptoms that you have or have had previously. I want all the facts about your health before I accept your case.

- | | | |
|--|--|--|
| Acne
Abdominal cramps
Addiction (drugs/alcohol)
Allergies
Anemia
Ankle swelling
Anxiety attacks
Anorexia
Anxiety
Appetite changes
Arthritis

Black/blood stools
Bladder problems
Bloating/gas/indigestion
Blood pressure problems
Blood sugar problems
Breast lumps
Breast pain
Bronchitis
Cancer
Chest Pain
Chronic fatigue
Cold or flu (frequent)
Cold extremities
Cold sore
Colitis
Constipation
Convulsions

Dental problems
Depression
Diabetes type I
Diabetes type II
Diarrhea
Difficulty loosing weight
Difficulty gaining weight
Dizziness
Ear infections (recurrent)
Emotional problems
Emphysema
Epilepsy
Excessive thirst
Excessive urination | Fainting
Fatigue
Fever
Forgetfulness
Frequent nausea
Gall Bladder
Genital herpes
Gout

Hair loss or poor growth
Headaches
Hearing loss or difficulty
Heart disease or problems
Heartburn
Hemorrhoids
Herpes simplex or type II
High cholesterol
HIV
Hot flashes
Hypoglycemia
Irregular heartbeats
Irritability
Kidney Stones
Liver problems
Loss of sleep

Mental disorder
Memory loss or confusion
Migraines
Neck pain
Nervousness
Painful urination
Panic attacks
Paralysis
Parasites
Pneumonia
Pregnant or nursing
Prostate problems
Ringing ears
Seizures
Server mood swings
Sexual dysfunction
Shortness of breath
Skin conditions | Sleep Issues
Sore throat
Stroke
Stuff nose
Suicidal tendencies
Sweaty palms
Tension
Thyroid conditions
Tingling extremities
Ulcer
Urine discoloration
Varicose veins
Vision problems
Vomiting
Yeast infections

Women:
PMS
Irregular periods
Pain periods
Loss of period
Birth control pills
Menopause
Painful intercourse
Menstrual cramps
Vaginal infections
Fertility problems
Are you pregnant? Yes _ No _

Men:
Frequent urination
Difficulty urinating
Difficulty with erection
Loss of libido
Prostate enlargement

Children:
Poor attention / Poor behavior
In-coordination / Speech
Colic / Suckling Difficulties/Sleep
Sporting Injuries |
|--|--|--|

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD OR HAVE NOW:

AIDS	Chorea	Fever blisters	Miscarriage	Scarlet fever
Alcoholism	Cold sores	Goiter	Multiple sclerosis	Stroke
Anemia	Diabetes	Gout	Mumps	Tuberculosis
Appendicitis	Diphtheria	Heart disease	Pleurisy	Typhoid fever
Arteriosclerosis	Eczema	Lumbago	Pneumonia	Ulcers
Arthritis	Emphysema	Malaria	Polio	Venereal disease
Cancer	Epilepsy	Measles	Rheumatic fever	Whooping cough

Have you ever had previous chiropractic care? _____ If yes, date of last care _____ Place care was given _____

What is your current health complaint? _____

How long have you had this condition? _____ Have you had this in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? _ Yes _ No _ Constant _ Comes and goes

Is this condition interfering with your: _ work _ sleep _ daily routine _ Other _____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

List previous diagnoses and treatments you have received for present condition _____

List surgical operations and years _____

List the drugs you now take and how often _____

Are you wearing: _ heel lifts _ sole lifts _ inner soles _ arch supports

Have you been in an auto accident: _ past year _ past five years _ over five years _ never

Describe _____

HABITS	Heavy	Moderate	Light	None	List Below all the conditions for which you have been treated in the past ten years.
Alcohol					
Coffee					
Tobacco					
Drugs					
Exercise					
Sleep					
Appetite					
Soft Drinks					

Name of relative or close friend not living in your home who can be contact in case of emergency.

NAME _____ PHONE _____

ADDRESS _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that I will be filing my receipts with my insurance company for reimbursement. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby give my consent to be examined at this office. I consent to allow the doctor to seek inter-and intra-professional advice relating to my particular case in order to obtain additional or collateral information that may be required to reach a complete and accurate diagnosis. Notwithstanding the foregoing, complete confidentiality of my records is assured.

24 hours notice is required for cancellation of an appointment. Without advance notice, full price will be charged.

A \$30.00 service charge will apply to all N.S.F. checks.

I understand that my acceptance as a patient at this office is contingent upon the opinion of the examining doctor that I have a condition that is amenable to chiropractic care. If chiropractic cannot help me, I will not be accepted as a patient, but will be referred to an appropriate health care faculty.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

Doctor-Patient Relationship in Chiropractic

INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give chiropractic adjustments, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of licensed providers in your health care regime.

RESULTS

The purpose of our services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through our procedures. In turn, we must admit that conditions, which do not respond to our care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor BEFORE signing this statement of policy.

I have read, and understand the foregoing.

Signature

Date
