New Patient Information

Waller Family Gonstead Chiropractic
4210 Ridge Road, Suite 102
Heath, TX 75032
972-722-0054

Date: _____

Name: _____ DOB: _____ Male: _____ Female: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone _____

Marital Status: _____ Occupation: _____

Who referred you to our office? _____

Chiropractic health history: Please indicate if you have any of the following: use back of page if needed.

Surgeries: _____ Broken bones: _____

Major Traumas (accidents/falls): _____

Hospitalizations: _____ History of Cancer _____

Do you take blood thinning medications: _____

Birth defects: _____ History of stroke: _____ High blood pressure: _____

List any other health information you think the doctor should know: _____

_____

_____

Doctor's Area: (DO NOT WRITE BELOW)

Pain Diagram

Name _____ Date _____ DOB _____

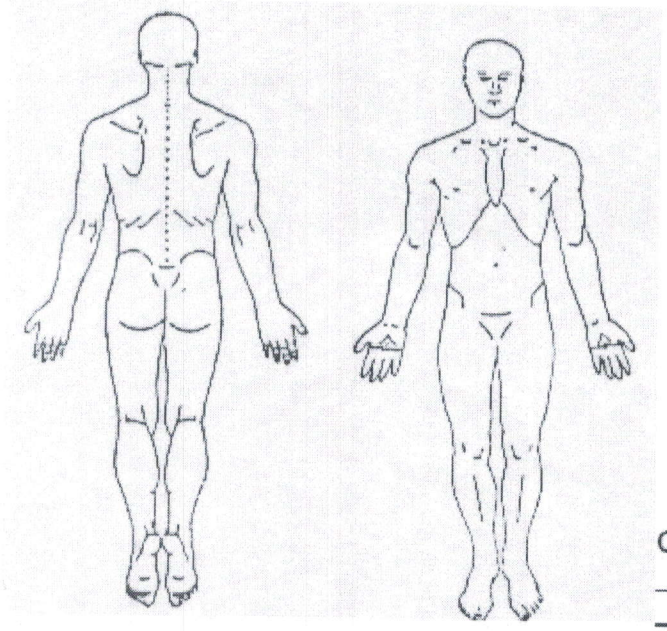
Current Complaints

Please List your symptoms in order of importance:	Date Began	For each symptom circle the number that best represents your current discomfort:
1. _____	_____	1. 0 1 2 3 4 5 6 7 8 9 10
2. _____	_____	2. 0 1 2 3 4 5 6 7 8 9 10
3. _____	_____	3. 0 1 2 3 4 5 6 7 8 9 10
		none mild moderate severe pain

Check the box below that represents how each symptom is affecting your daily activities:		Check the box that best describes the amount of time you spend in the discomfort for each symptom:	
1. __Doesn't affect	__Somewhat affects	1. __ Up to 1/4 of awake time	__1/4 to 1/2 of time
__ Seriously affects	__ Prevents activities	__ 1/2 to 3/4 of awake time	__ Most all the time
2. __Doesn't affect	__Somewhat affects	2. __ Up to 1/4 of awake time	__1/4 to 1/2 of time
__ Seriously affects	__ Prevents activities	__ 1/2 to 3/4 of awake time	__ Most all the time
3. __Doesn't affect	__Somewhat affects	3. __ Up to 1/4 of awake time	__1/4 to 1/2 of time
__ Seriously affects	__ Prevents activities	__ 1/2 to 3/4 of awake time	__ Most all the time

Please indicate the appropriate location of pain and discomfort on the diagram by using the symbol that best describes what you are presently experiencing:

+ + Ache = = Burning * * Numbness
! ! Stabbing ^ ^ Throbbing \ \ Other



Actions Affecting your Pain

	Brings On	Aggravates	Relieves
In the A.M.	☐	☐	☐
In the P.M.	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Bending right	☐	☐	☐
Bending left	☐	☐	☐
Twisting right	☐	☐	☐
Twisting left	☐	☐	☐
Coughing	☐	☐	☐
Sneezing	☐	☐	☐
Straining	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lifting	☐	☐	☐
Other Actions:			
_____	☐	☐	☐
_____	☐	☐	☐

What may have caused your current symptoms? _____
What have you done to treat your symptoms? _____

Signature: _____

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Health Insurance Portability & Accountability Act (HIPPA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purpose of the treatment, payments, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may request this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

[ ] I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

[ ] I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: _____ **Date**_____

Assignment of Benefits

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date at which it is filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.

Patient or Parent Signature: _____ **Date**_____

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my care. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risk of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

I hereby acknowledge that if I do not keep appointments as recommended by my treating doctor, he/she has the complete right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: _____ Date_____

***I, the undersigned parent or legal guardian of** _____ **(minor child), hereby give my permission to the staff of Waller Family Chiropractic to treat said child.**
Parent Signature: _____ **Date**_____