Walker Chiropractic Clinic

Welcome

105 Boland Street
Fort Worth, TX 76107-1221

Phone: 817-332-1234
Fax: 817-332-1473

Personal Information

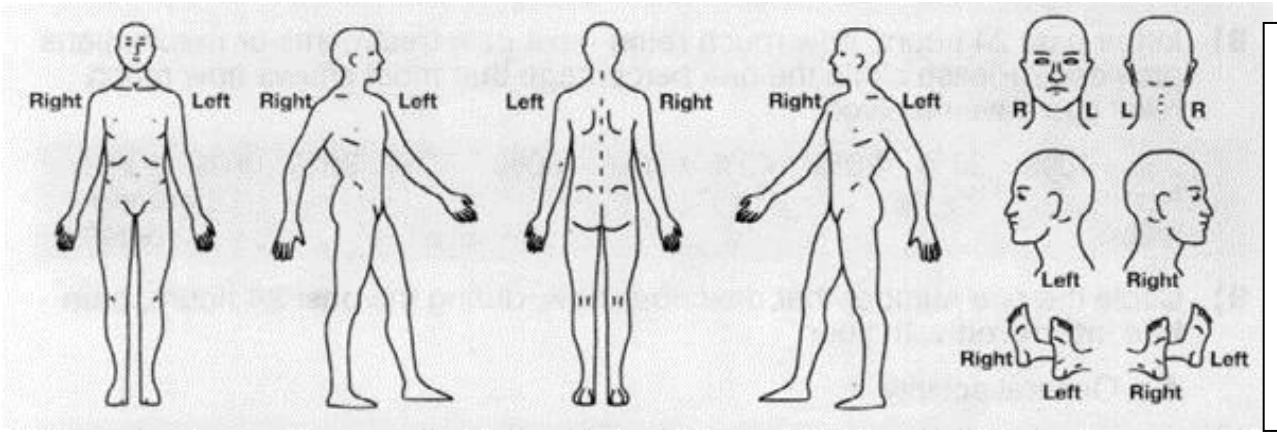
Name _____ Date _____
Address _____ Date of Birth _____
City _____ State _____ Zip _____ Social Security _____
Email Address: _____
Home Phone _____ Cell Phone _____ Work Phone _____
Occupation _____ Employer _____
Sex: Male_____ Female _____ Height _____ Weight _____ Age _____
Marital Status: Single _____ Divorced _____ Widowed _____ Married _____ Spouse's Name_____
Race: (Circle) White, American Indian, Asian, Black, Hispanic, Other _____ Declined to state_____
Preferred Language: English _____ Other (Specify) _____
Whom may we thank for referring you? _____

Insurance Information

Do you have health insurance? ____ No ____ Yes Name of Insurance _____
Address: _____ Phone: _____
Id#_____ Group # _____

Reason for Visit

What prompted today's visit? If in pain, please describe the pain & its location: _____
_____



Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
O=Other
B=Burning
P=Pins & Needles
N=Numbness
S=Stabbing

Is the pain associated with? (Circle) Work injury, Auto injury, Sports, Chronic pain. When did the pain / injury occur? _____
How did this occur? _____
Is this condition getting worse? Yes ____ No ____ Constant ____ Comes and Goes ____ Have you had this condition in the past? Yes No
Is this condition interfering with you're: Work _____ Sleep _____ Daily Routine _____ Please explain _____
What if anything makes the condition better? _____
What if anything makes the condition worse? _____
Have you ever been treated by a Chiropractor before? No ___ Yes _____ How long ago_____ By Whom _____

Health History

Surgeries: Knee Replacement _____ Hip Replacement _____ Gall Bladder _____ Hernia _____ Hysterectomy _____ Heart_____
Other _____Accidents or Falls: Please describe _____
_____

Are you taking any prescription medication? ❑Yes ❑No
If Yes, please list:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Do you have allergies to medication? ❑Yes ❑No
If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____

Smoking Status: ❑Current every day smoker ❑Current some day smoker ❑Former smoker ❑Never smoker

Have you ever had any of the following diseases/ medical conditions?

❑Frequent Neck Pain	❑Numbness: Arm, Hands, legs	❑Heart Surgery/Pacemaker	❑Loss of weight
❑Headaches: frequent/severe	❑Arthritis	❑Congenital Heart defect	❑Difficulty Breathing
❑Pain between shoulders	❑Poor Circulation	❑Heart Murmur	❑Asthma
❑Low Back Problems	❑Fatigue/Stress	❑Heart attack/ Stroke	❑Diabetes/Tuberculosis
❑Painful tailbone	❑Loss of Sleep	❑Fainting/ Seizures	❑Failing vision/ Glaucoma
❑Leg Pain	❑High/ Low Blood Pressure	❑Dizziness	❑Alcohol/ Drug abuse

If you are here due to a **car wreck or worker's compensation** related injury please complete the following.
Otherwise please skip to the next page.

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: _____
Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: _____
Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: _____
Insurance/ Attorney_____ Adjuster or Contact Person _____
Address_____ Phone _____ Claim # _____
Briefly describe the accident, injury or illness:_____
_____
List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
List any tests, studies or medications received for this condition:
❑Tests/Studies: _____
❑Medications: _____
Where you admitted to the hospital due to this condition: ❑Yes ❑No
If yes, what hospital? _____Transported by? ❑Ambulance ❑Police ❑Other: _____
Date Admitted: _____ Date Released: _____ Length of Stay: _____
List the hospital procedures received:_____
List symptoms you are experiencing today: Choose the severity level associated with each symptom
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
_____ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe
Do you have any current work restrictions due to this condition?
Off work: ❑Yes ❑No ❑Previously From: _____ To: _____
Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) _____
_____
What type of work do you do? _____

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
and "Chiropractor" refers to Walker Chiropractic Clinic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. **I hereby assign benefits payable and instruct direct payment to Walker Chiropractic Clinic.** I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.
I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The Notice of Privacy Practices of Chiropractor is available to me I and understand that I have a right that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 105 Boland st., Fort Worth. This Notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information.

I have the right to view a summary of my healthcare records either in person or via secure website, at my request.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority

Medicare

In accordance with the Medicare Act, This section is to advise you that x-rays or ultrasound therapy is a non-covered service by medicare.
I hereby assign benefits payable and instruct direct payment to Walker Chiropractic Clinic.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority