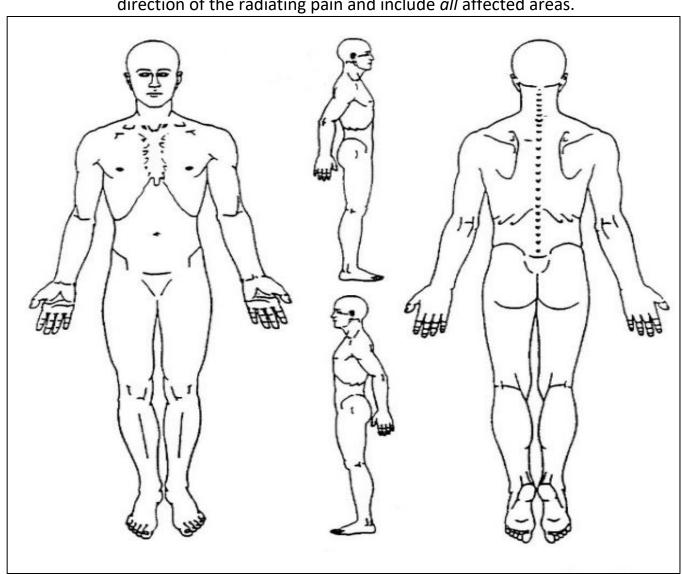


Data: Time:	Use Only	A act Tree	
Date: Time:			
Height: Weight:	BP:	/ Pulse:	
PATIENT INTA	AKE FORM		
Name:	_ Preferred to be ca	lled:	
Date of Birth://	Sex: M F	Marital Status:	S M D V
Address:	City:	State:	Zip:
Phone (Cell): Email:			
Emergency Contact Name: Emergency Co	ontact Phone:	Relation:	
Work Status:EmployedUnemployedStudentRetired	Employer:	Occupatio	on:
How did you hear about our office?	Referred by:		
Subscriber Name: Relation Subscriber Date of Birth:/			
	edicare providers, pleas	e see the front desk for	
Subscriber Date of Birth://	edicare providers, pleas Chiropractic Ca	e see the front desk for	further details)
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Subscriber Date of Birth://	Chiropractic Can	e see the front desk for	further details)
Subscriber Date of Birth: / / / Are you covered under Medicare? YES NO (we are not Me Reasons for Seeking Primary Condition: Secondary Condition/any other areas of concern: Date of Onset: Briefly describe the condition and the condition of the conditio	Chiropractic Cartion or accident, injusting what	e see the front desk for	further details)

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Mark the area on the body figures below where you feel the described sensation or pain. Mark the areas where pain radiates or spreads with arrows $(\rightarrow, \leftarrow, \land, \land, \lor, \land)$ to indicate the direction of the radiating pain and include *all* affected areas.



Please circle the Quality of the complaints/pain:

Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing Absent

Frequency of symptoms:

Occasional. Intermittent Frequent Constant Absent

Grade Intensity/Severity:

(No complaint) **0 1 2 3 4 5 6 7 8 9 10** (Very severe pain)



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PAST HEALTH HISTORY

Social History: How often do you exercise? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes	Never Never
How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes	
How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes How often do you smoke? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes How often do you smoke? Daily Weekly Sometimes	Never
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How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes How often do you smoke? Daily Weekly Sometimes	Never
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How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes	Never
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How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes How often do you drink alcohol? Daily Weekly Sometimes	Never
How often do you exercise? Daily Weekly Sometimes	
How often do you exercise? Daily Weekly Sometimes	
How often do you exercise? Daily Weekly Sometimes	Never
·	Never
·	Never
Social History:	
Medications: Reason for taking	
Medications: Reason for taking	
/itamins/Supplements: Reason for taking	
litamina (Cumplementa)	
Surgeries: Type of Surgery: _	
njections: Date: Reason for taking:	;:
niections: Nate: Reason for taking:	,,
maging: Date: Reason for taking:	<u></u>
Γests/Studies: Date: Reason for taking:	<u></u>



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REVIEW OF SYSTEMS

Mark any of the following that you are currently or have previously experienced. If none apply, please choose 'Deny All' for each category.

CONSTITUTIONAL

DENY ALL

- o Chills
- Drowsiness
- Fainting
- o Fatigue
- Fever
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

INTEGUMENTARY

□ DENY ALL

- Breast Lumps/Pain
- Change in Nail Texture
- o Change in Skin Color
- o Eczema
- Hair Growth
- Hair Loss
- History of Skin Disorders
- o Hives
- Itching
- o Paresthesia
- Rash
- Skin Lesions

PSYCHIATRIC

□ DENY ALL

- Agitation
- Anxiety
- o Appetite Changes
- Behavioral Changes
- Bipolar Disorder
- Confusion
- Depression
- Homicidal Indication
- o Insomnia
- Location disorientation
- Memory Loss
- Substance Abuse
- Suicidal Indication
- Time Disorientation

EYES

□ **DENY ALL**

- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Dry Eyes
- o Eye Pain
- Field Cuts
- o Glaucoma
- Light Sensitivity
- Tearing
- Wears Glasses

ENMT

□ DENY ALL

- Bad Breath
- o Dentures
- o Deviated Septum
- Difficulty Swallowing
- Discharge
- o Dry Mouth
- o Ear Drainage
- Ear Pain
- Frequent Sore Throats
- Head Injury
- Hearing Loss
- Hoarseness
- Loss of Smell
- Loss of Taste
- Nasal Congestion
- Nose Bleeds
- Postnasal Drip
- Sinus Infections
- o Runny Nose
- Snoring
- o Ringing in Ears
- o TMJ Problems
- Ulcers

CARDIOVASCULAR

□ DENY ALL

- o Angina/Chest Pain
- Claudication
- o Heart Murmur
- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Orthopnea
- o Palpitations
- Shortness of Breath
- Swelling of Legs
- Varicose Veins

GASTROINTESTINAL

□ **DENY ALL**

- Abdominal Pain
- o Belching
- Black, Tarry Stool
- Constipation
- o Diarrhea
- Heartburn
- o Hemorrhoids
- Indigestion
- o Jaundice
- Nausea
- o Rectal Bleeding
- Abnormal Stool
- Caliber
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood



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ENDOCRINE

□ DENY ALL

- Cold Intolerance
- Diabetes
- Excessive Appetite
- o Excessive Hunger
- Excessive Thirst
- o Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

RESPIRATORY

□ DENY ALL

- o Asthma
- o Bronchitis
- Dry Cough
- Productive Cough
- Coughing Up Blood
- Difficulty Breathing
- Difficulty Sleeping
- o Hemoptysis
- o Pneumonia
- o Sputum Production
- Wheezing

GENITOURINARY

☐ **DENY ALL**

- Birth Control Therapy
- o Burning Urination
- Cramps
- o Erectile Dysfunction
- o Frequent Urination
- o Hesitancy/Dribbling
- Hormone Therapy
- Irregular Menstruation
- Lack of Bladder control
- Prostate Problems
- o Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

HEMATOLOGIC/LYMPHATIC

☐ DENY ALL

- o Anemia
- Bleeding
- Blood Clotting
- o Blood Transfusion
- o Bruise Easily
- Lymph Node Swelling

MUSCULOSKELETAL

□ DENY ALL

- Arthritis
- Neck Pain
- Decreased Motion
- o Gout
- o Injuries
- o Joint Pain
- Joint Stiffness
- Locking Joints
- o Back Pain
- Muscle Cramps
- Muscle Pain
- Muscle Twitching
- o Muscle Weakness
- Swelling

NEUROLOGICAL

□ DENY ALL

- Change in Concentration
- Change in Memory
- Dizziness
- Headache
- o **Imbalance**
- Loss of Consciousness
- Loss of Memory
- Numbness
- o Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- o Strokes
- Tremors

ALLERGIC/IMMUNOLOGIC

□ DENY ALL

- History of Anaphylaxis
- Itchy Eyes
- Sneezing
- Specific Food Intolerance



CONSENT TO CHIROPRACTIC/ A.R.T. CARE

ChiroSport Specialists of Dallas strives to ensure the highest quality care to our patients. All fields of healthcare are associated with potential risks. In order to provide you health care services, it is our lawful obligation to ensure you an Informed Consent of Treatment, where you fully understand the potential benefits and risks associated with chiropractic, physical therapy and A.R.T.

The chiropractic adjustment or manipulation involves the movement of a joint, or the space between the two bones. This may be performed on any joint in the body. Our doctors utilize their hands in order to perform the adjustment therefore the doctors' hands may contact the patient's back, hips, knees, ribs, neck, ankle, or other "bony" areas. The patient must understand that the soft tissues that cover the bones/joints may be contacted to perform an adjustment and it is VERY IMPORTANT that you understand the distinction to prevent any misconstrued event. A "popping" sound is a normal occurrence that can be heard or felt when the adjustment is performed; know that it is the quick controlled thrust into the joint that results in a release of Nitrogen gas within the fluid of a joint capsule as it moves. The adjustment is usually not painful.

Our doctors specialize in Active Release Techniques (A.R.T.) which focuses on care of soft tissue injuries. Some conditions may require 2 to 3 weeks to determine if ART will be effective for your condition. If A.R.T. is not effective in improving your condition our providers will inform you and redirect your care. Most patients that seek A.R.T. have symptoms caused by scar tissue, which has formed on muscles, ligaments and nerves causing pain, lack of motion, and difficulty with daily activities. These symptoms can unfold over a period of days or even years. A.R.T. is used to break up the scar tissue between the muscles identified to be causing the issues and in conjunction with chiropractic care you are introduced to specific stretches to perform through the day to help the recovery process and prevent reoccurrence. Your A.R.T. sessions may be uncomfortable; everyone's tissue tolerance is different, and it is your responsibility to communicate with the doctor during and after care to give feedback so that modifications can be made if necessary. It is unlikely that bruising will occur after a session, however, if this occurs speak to your doctor and they can apply less force in future treatments.

Our facility uses the newest tools in treatment, recovery and alternative care. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound may be used for treatment. Other tools such as instrument assisted soft tissue mobilization (I.A.S.T.M.), cupping, compression therapy and laser therapy are a few of the additional treatments the doctors may include to your treatment/care plan. Soreness in the area of treatment is common following chiropractic adjustments, A.R.T., traction, cupping, I.A.S.T.M, physical exercise and massage. Confidence and trust in your personal health provider is of utmost importance, as primary treating doctors we can manage your injury and refer you for the necessary testing and evaluations required. It is your responsibility to participate in your care by doing the stretches and at-home care plan you will be taught, as well as communicating with your doctor whether you feel the care is helping you.

Possible risks and complications, as with any health care procedure, are possible following a chiropractic manipulation. Complications can include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to the intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications like a blister may occur again in rare occurrence but tell your doctor if this occurs. The risks of complications due to chiropractic treatment have been described as "rare". Rib Fractures in the thoracic spine rarely occur and are usually associated with patients with weakened bone structure like osteoporosis. Disc Herniations, although frequently successfully treated by chiropractors, can occasionally aggravate the problems and rarely will surgery become necessary. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million about as often as complications are seen from the taking of a single aspirin tablet and can be even further reduced by screening procedures. Over the counter and prescription medications can decrease the symptoms but may produce undesirable adverse reactions such as nausea, headaches, dizziness, back pain, bleeding and other effects.

DO NOT SIGN BELOW UNTIL YOU HAVE READ AND COMPLETLEY UNDERSTAND THE ABOVE INFORMATION, if you have any questions or concerns, please ask your doctor.

By signing below, I state that I have read or had read to me the explanation of the Chiropractic, physical therapy, A.R.T. and alternative methods related to treatment. I understand the type of treatment, I understand that the ART program is an elective course of care that I can withdraw from at any time by notifying the doctor. I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or said minors' interest) to undergo the treatment recommended. Having been informed I hereby give my consent to ChiroSport Specialists of Dallas staff and doctors to perform treatment. I also acknowledge that no guarantee or assurance to the treatment results associated with any symptoms, disease or condition as a result of the treatment received at this clinic may be obtained. I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize ChiroSport Specialists of Dallas to provide me with chiropractic care, in accordance with this state's statutes.

Patient Name	Patient/Guardian Signature	Date



CONSENT OF INTERNS	SHIP STUDIES, PHOTO & VIDEO RELEASE	Initials:
I acknowledge that ChiroSport and staff, if I am not comfortable doctors, staff or any of their aphotographs and videos will be publications, social media, and could be used unless stated differ videos. If I wish to revoke the	Specialists of Dallas is a teaching facility that at times has interple with another person in my treatment room, I will let the document of the designees may take photographs and videos of my treatment used as a record of my care and may be used for communication advertising. I further understand that if the photographs or vide ferently below. I do not expect compensation, financial or other is consent, I may do so in writing. If declining this consent, leave we for internship studies, and the use of my photos and videos as	ctor know. I also acknowledge that our care at their facility. I understand the in with other health care professionals, os are used my identifying information wise, for the use of these photographs to blank.
PRIVACY POLICIES		Initials:
_	Sport Specialists of Dallas privacy policies are available upon r by HIPAA guidelines, these notices describe how your protected access to this information.	
CANCELLATION AND "	'NO SHOW" POLICY	Initials:
MUST PROVIDE A TWENTY-FOR Patient appointments and 24 h	ntment times with ChiroSport Specialists of Dallas Doctors, our our our continuation of the Cancellation Notice for all services. Failure to continuate for existing patient appointments in advance or not showing paid prior to any future appointments or will be billed at the expanding prior to any future appointments.	tact the office at least 48 hours for New ng up for an appointment will result in
INSURANCE AND PAY	MENT POLICY	Initials:
Discover. All medical services pyour insurance carrier, we will a carrier offers; we are contracted balance deemed patient respowe will file to your insurance afrom your insurance carrier. Pabilling office. We will extend a	the time services are received. We accept cash, checks, VISA provided are directly charged to the patient or responsible party accept their negotiated rate for the charges billed. We are not all with most BCBS PPO, BCBS HMO, AETNA, HUMANA plans. It is nsibility/non-covered by your insurance and billed accordingly, and any remaining balance will be billed to you after we receive syment is expected in full upon receipt of statement or payment as 90-day period for your carrier to process claims and issue any sayment, all charges due will become member responsibility and terms of the payment policy.	If our physicians are contracted with always contracted with every plan each dowever, you will be responsible for a If you have not met your deductible, the explanation of benefits statement arrangements must be made with our y payments due. If after 90 days your
AUTO-BILL POLICY		Initials:
Credit/Debit Card billing inform in each individual account and however, each must be entered balances and charges for Late C day. I understand that my pay	nation may be stored and used for all patient charges incurred. The dimay not be transferred between accounts. Same cards may ed/saved separately. Co-insurance amounts, payment for services and the company of the charges may be made acceptable charges may be stored securely and understand and accest incurred. To utilize the Auto-Bill Program see the front desk	nis information is encrypted and stored y be used amongst multiple accounts vices, supplies or therapies as well as nade at the end of the business/service acknowledge the use of my Auto Bill
Patient Name	Patient / Guardian Signature:	Date:

Doctor Name: _____ Doctor Signature: _____ Date: _____