TEXSTAR CHIROPRACTIC

Name: _____ Date: _____ File #: _____ Case Type: _____

Sex: _____ Birth Date: _____ Age: _____ Social Security #: _____

Address: _____ _____ _____ _____
Residence and Mailing | City | State | Zip Code

Home Phone: _____ Mobile Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Marital Status: S M D W Spouse's Name: _____ Spouse's Birth Date: _____

No. of Children: _____ Emergency Contact: _____ Contact Phone: _____

How did you hear about us? _____Google _____Patient Referral (Please Name) _____

_____Yelp _____Doctor Referral (Please Name) _____

_____Insurance Co. _____Other (Please List) _____

Primary (First) Complaint and Location

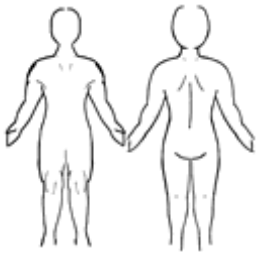
Chief Complaint (Reason for Visit): _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____ Yes _____ No _____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

_____ Sharp	_____ Shooting	_____ Stiffness	_____ Crawling	_____ Pulsating
_____ Dull	_____ Burning	_____ Deadness	_____ Pins and Needles	_____ Prickly
_____ Throbbing	_____ Tingling	_____ Stabbing	_____ Stinging	_____ Pounding
_____ Aching	_____ Cramping	_____ Numb	_____ Excruciating	

What makes it worse?

_____ Sitting	_____ Lifting	_____ Driving	_____ Looking Down	_____ Sneezing
_____ Standing	_____ Coughing	_____ Walking	_____ Rotating Head	_____ Carrying
_____ Bending	_____ Straining	_____ Exercising	_____ Stress	_____ Climbing Stairs
_____ Lying Down	_____Getting out of bed	_____ Looking Up	_____ Bright Lights	_____ Repetitive Movement

What makes it better?

_____ Ice	_____ Rest	_____ Pain Medications	_____ Lying Down	_____ Exercising
_____ Heat	_____ Tylenol	_____ Mineral Ice	_____ Sleeping	_____ Anti-inflammatory
_____ Massage	_____ Advil	_____ Muscle Relaxers	Other: _____	

What time of day is it worse? _____ Morning _____ End of day _____ Night _____ Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____ Work _____ Sleep _____ Daily Routine _____ Recreation _____ None

Have you seen other doctors for this condition? _____ Yes _____ No If yes, who? (Name) _____

Type of Treatment: _____ Are you satisfied with the results of the treatment? _____ Yes _____ No

Primary Care Physician: _____ Have you ever had Chiropractic care before? _____ Yes _____ No

Do you exercise? _____ None _____ Infrequent _____ Regular _____ Frequent and Heavy

Sufficient rest _____ Never _____ Rarely _____ Occasionally _____ Moderately

Hours of sleep _____ 3-4 _____ 5-6 _____ 7-8 _____ 9-10 _____ More than 10

Personal stress _____ Low _____ Medium _____ High _____ Very high

Occupational stress _____ Low _____ Medium _____ High _____ Very high

Well balanced diet _____ Never _____ Rarely _____ Occasionally _____ Regularly

Do you smoke? _____ No _____ Occasionally _____ 1 to 5 _____ 6 to 10 _____ 11-15 _____ Packs per day?

Do you drink alcohol? _____ No _____ Occasionally _____ 1 to 2 _____ 2 to 3 _____ 4 to 5 _____ More than 5 per day

Do you drink caffeine? _____ No _____ Occasionally _____ 1 to 2 _____ 2 to 3 _____ 4 to 5 _____ More than 5 per day

Secondary Complaint and Location

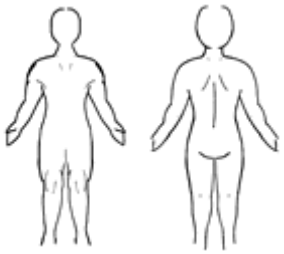
Secondary Complaint: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____ Yes _____ No _____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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_____ Dull _____ Burning _____ Deadness _____ Pins and Needles _____ Prickly

_____ Throbbing _____ Tingling _____ Stabbing _____ Stinging _____ Pounding

_____ Aching _____ Cramping _____ Numb _____ Excruciating

What makes it worse?

_____ Sitting _____ Lifting _____ Driving _____ Looking Down _____ Sneezing

_____ Standing _____ Coughing _____ Walking _____ Rotating Head _____ Carrying

_____ Bending _____ Straining _____ Exercising _____ Stress _____ Climbing Stairs

_____ Lying Down _____Getting out of bed _____ Looking Up _____ Bright Lights _____ Repetitive Movement

What makes it better?

_____ Ice _____ Rest _____ Pain Medications _____ Lying Down _____ Exercising

_____ Heat _____ Tylenol _____ Mineral Ice _____ Sleeping _____ Anti-inflammatory

_____ Massage _____ Advil _____ Muscle Relaxers Other: _____

What time of day is it worse? _____ Morning _____ End of day _____ Night _____ Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____ Work _____ Sleep _____ Daily Routine _____ Recreation _____ None

Third Complaint and Location

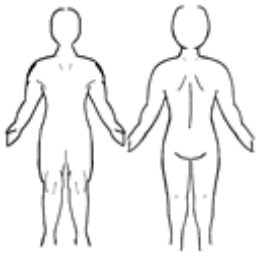
Third Complaint: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____ Yes _____ No _____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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What time of day is it worse? _____ Morning _____ End of day _____ Night _____ Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____ Work _____ Sleep _____ Daily Routine _____ Recreation _____ None

Past Health History

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Neurological Health History

_____ Facial Weakness	_____ Loss of Balance	_____ Sensation Loss	_____ Memory Loss
_____ Smell Disturbance	_____ Stroke	_____ Incontinence	_____ Dizziness
_____ Speech Disturbance	_____ Seizures _____	_____ Ringing in Ears	_____ Nervousness
_____ Visual Disturbance	_____ Numbness in Toes	_____ Headaches	_____ Stomach Upset
_____ Loss of Taste	_____ Numbness in Fingers	_____ Irritability	_____ Tension

Musculoskeletal Health History

_____ Abnormal Posture	_____ Disc Herniation	_____ Osteopenia	_____ Elbow Problem
_____ Osteoarthritis	_____ Degenerative Disc Disease	_____ Osteoporosis	_____ Wrist Problem
_____ Dislocation/Fracture	_____ Shoulder Problem _____	_____ TMJ Syndrome	_____ Ankle Problem
_____ Lower Back Pain	_____ Knee Problem _____	_____ Headaches	_____ Pes Planus
_____ Neck Pain	_____ Sprain/Strain _____	_____ Tendonitis _____	Other _____

Childhood Illnesses

_____ ADD / ADHD
_____ Allergies / Hay Fever
_____ Asthma
_____ Eczema
_____ Cerebral Palsy
_____ Chicken Pox
_____ Depression
_____ Diabetes (Type I)
_____ Fetal Drug Exposure
_____ Food Allergies
_____ Headaches
_____ Hepatitis
_____ Measles
_____ Mumps
_____ Rash
_____ Scoliosis
_____ Sickle Cell Anemia
_____ Ear infections
_____ Other _____
_____ Bed Wetting

Adult Illnesses

_____ Alzheimers
_____ Anemia
_____ CRPS (RSD)
_____ Cancer _____
_____ Chicken Pox
_____ Crohn's / Colitis
_____ Heart Disease
_____ Kidney Problems
_____ Depression
_____ Diabetes (Type II)
_____ Liver Disease
_____ Emphysema
_____ Eye Problems
_____ Fibromyalgia
_____ Parkinson's Disease
_____ STD's (unspecified)
_____ Hypertension
_____ Pneumonia
_____ Seizure Disorder
_____ Hepatitis
_____ Lupus Erythema
_____ Multiple Sclerosis
_____ Vertigo
_____ Other _____
_____ Psychiatric Problems
_____ Scoliosis
_____ Asthma
_____ Suicide Attempt(s)
_____Thyroid Problems
_____ Ear Infections (frequent)

Past Surgeries

_____ Angioplasty
_____ Appendectomy
_____ Ceaserian Section
_____ Carpal Tunnel Repair
_____ Coronary Artery Bypass
_____ Cosmetic
_____ D & C
_____ Rotator Cuff
_____ Hemorrhoidectomy
_____ Hernia Repair
_____ Hysterectomy
_____ Gallbladder
_____ Laminectomy _____
_____ Mastectomy
_____ Pacemaker Insertion
_____ Knee Replacement
_____ Spinal Fusion _____
_____ Tympanostomy
_____ Cardiac Catherization
_____ Hip Replacement
_____ Other _____
_____

Current Medications

_____ _____ _____
_____ _____ _____
_____ _____ _____

Vitamins and Supplements

_____ _____ _____
_____ _____ _____
_____ _____ _____

Known Drug Allergies

_____ _____ _____
_____ _____ _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____
Signature (Patient or Guardian) *Date*

Financial / Insurance Information

Who is responsible for this account? _____Relationship to patient: _____

Health Insurance Company Name: _____2nd Ins. Co. Name: _____

Denial of Work/Auto Accident

I confirm that the treatment I am requesting to receive today is NOT for injuries sustained in an automobile accident or work-related accident.

_____ _____

Signature (Patient or Guardian) *Date*

Auto Accident Information

If you were in a Motor Vehicle Accident, please list YOUR Auto Insurance information:
(We do not bill 3rd Party Automobile Insurance Companies. See MVA Financial Policies Page for details.)

Auto Insurance Company Name: _____ Phone # _____

Claim #: _____Adjuster Name: _____Phone # _____

Financial Policies / Fee Schedule

I understand that health and accident policies are an arrangement between my insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collections from my insurance company. **Ultimately, I am responsible for all services rendered, including those not reimbursed by my insurance company.**

Services	**Fees**
Initial 5-minute Consultation	Complimentary
New Patient Exam	$100.00
X-Rays	$45.00 - $270.00
Non-Surgical Spinal Decompression	$75.00
Interim/Update Examination	$60.00
MLS Robotic Cold Laser (per body area)	$55.00
Chiropractic Adjustment	$50.00
Care Coordination and Counseling	$40.00
Interferential Stimulation Therapy	$25.00
Intersegmental Traction Therapy	$20.00
Kinesio Taping	$15.00-$30.00

I have read and understand the above financial policies.

_____ _____

Signature (Patient or Guardian) *Date*