NEW PATIENT INFORMATION

Health by Hands WELLNESS CENTER

12619 FM917, Suite A
Alvarado, TX 76009

817-930-0600
www.healthbyhandswellness.com

Demographic Information

*Denotes required information

Welcome!
Please allow our staff to photocopy your driver license and all available medical documents or insurance cards.

Office Use Only Initial When Done
____ Consent Forms Signed
____ Started New Note
____ Email in CC list

Patient Name

Title: _____
Nick Name: _____
*First Name: _____
Middle Name: _____
*Last Name: _____
Suffix: _____

Address

Address 1: _____
Address 2: _____
City: _____
State: _____
*Zip: _____

Contact Information

Primary phone: _____
Secondary phone: _____
*Mobile phone: _____
*Text Message Appointment Reminder: ___Yes ___No
Work email: _____
*Home email: _____
Best Contact Method: _____

Personal Information

*Date of Birth: _____
Social Security #: _____
*Gender: _____
*Marital Status: __ Single __ Married __ Other
*Employment Status: __ Employed __ FT Student __ PT Student __ Retired __ Other __ Self Employed
Race: __ White __ Black/African American __ Hispanic __ American Indian/Alaska Native
__ Asian Indian __ Chinese __ Filipino __ Japanese __ Korean __ Vietnamese
__ Native Hawaiian/Pacific Islander __ Guamanian or Chamorro __ Samoan __ Other
*Multi-Racial: __ Yes __ No
*Ethnicity: __ Hispanic or Latino __ Non-Hispanic or Latino
*Preferred language: _____

*Verification Question:
__ In what city were you born?
__ What high school did you attend?
__ What is your favorite color?
__ What is your favorite movie?
__ What is the name of your favorite pet?
__ What street did you grow up on?
__ What was the make of your first car?
__ When is your anniversary?

*Verification Answer **(At least 6 characters):** _____
Name of primary care physician: _____
Have you ever consulted a chiropractor before? __ Yes __ No
If so, who: _____
Last visit: _____
Referred by: _____

Patient Name:_____ DOB: ___/____/_____

Employment Information

* Denotes required information

*Occupation: _____
Employer Name: _____
Employer Address: _____
Employer City: _____
Employer State: _____
Employer Zip: _____
Work Phone: _____
May we call your cell phone at work: __ Yes __ No
May we call your work phone: __ Yes __ No
***Physical Stress level:** ___Low ___Medium ___High
*Injured on the job: ___Yes ___No
*Job Description:_____
*Activities: _____

Other Health Care Providers

* Denotes required information

*Provider Name: _____
Provider Type: _____
Provider City: _____
Provider State: _____
Provider Phone: _____
*I have seen this provider for my primary problems: __ Yes __ No

*Provider Name: _____
Provider Type: _____
Provider City: _____
Provider State: _____
Provider Phone: _____
*I have seen this provider for my primary problems: __ Yes __ No

*Provider Name: _____
Provider Type: _____
Provider City: _____
Provider State: _____
Provider Phone: _____
*I have seen this provider for my primary problems: __ Yes __ No

Patient Name:_____ DOB: ___/____/_____

We want you to know how your Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. A more detailed account of our policies and procedures concerning the privacy of your Patient Health Information are included in the HIPAA notice ("Notices of Privacy Practices") that is part of the New Patient Package and it is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the Insurance companies require for payment.

2. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

3. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

4. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse to give care.

I have read and understood how my personal information will be used and I agree to these policies and procedure.

Patient's signature_____ Date_____

or

Parent's or Guardian's Signature_____ Date_____

Patient Name:_____ DOB: ___/____/_____

HEALTH PROBLEMS AND CONCERNS: Please Print and List your top health concerns in order of priority

1._____

2._____

3._____

4._____

5._____

TREATMENT: What type of treatment are you looking for? _____

☐ I am looking for the most minimal amount of care to "patch up" my problem. ☐ I am looking to resolve my symptoms, then go on to "fix the cause" ☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

Have you had any intolerance or reactions to treatments? ☐Yes ☐ No
Describe:_____
_____

Have you ever been in the emergency room? For what reason and when? _____

Have you ever been on crutches? For what reason and how long? _____

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never. If yes, describe:
_____
_____

Surgeries & Trauma What surgeries, trauma, or stitches have you had and when? _____
_____
_____

Have you had elective surgery (tummy tuck, face lift, liposuction, etc.) ?_____

Have you ever had full-body anesthesia (i.e. to remove tonsils, wisdom teeth, etc)? _____

Metal or plastic inside your body (pins, clamps, plates)? _____

Breast implants _____, Prostheses _____, Body piercing _____, Tattoos _____

Women: Last menstrual period: ___/ ___/_____ Are you pregnant? ☐**Y** ☐**N**; Taking birth control pills? ☐**Y** ☐**N**

Nr of pregnancies ___; Nr of children: ____; Miscarriages/Abortions:_____; Complications: _____

☐Vaginal bleeding other than period ☐Painful menstrual periods _____

☐ Back pain with menstrual periods ☐Other menstrual problems _____

☐ Pap smear within last two years

Patient Name:_____ DOB: ___/____/_____

Problem Areas - Use a Body diagram and a Problem Sheet for each Problem

* Denotes required information

***Describe your problem #1:** _____

*On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
(0 = no pain; 1-3 = aware of pain, but can carry on activities of daily routine; 4-7 = intermittent/certain motions produce pain; 8-10 = constant, severe, nothing makes it better without drugs).

***How did your problem begin:** _____

***Onset date of problem:** _____

How often do you experience symptoms: _____

What is the nature of your symptoms: (check all that apply)
__ Dull __ Sharp __ Throbbing __ Burning __ Deep
__ Aching __ Tingling __ Stabbing __ Cramping
__ Numbness __ Radiating

Does it affect other areas of your body: __ Yes __ No

To what areas does the pain radiate, shoot or travel: _____

***What makes it worse:** __sitting __standing ___walking __bending __stooping__ looking up __looking down __movement __climbing stairs __lying supine __lying prone __reaching __sneezing __sleeping __twisting __lifting __exercise __rest __ driving __typing __morning __afternoon __evening

Comments:
_____
_____
_____
_____

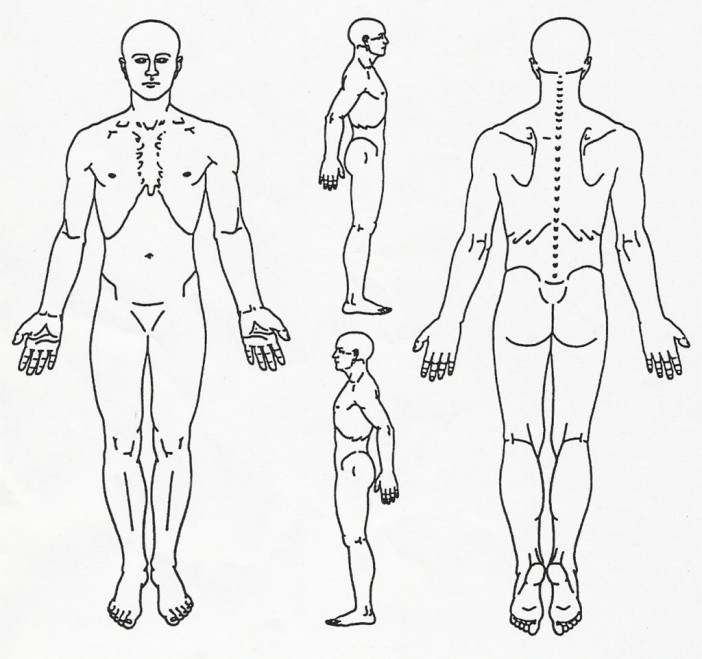
What makes it better: __ sitting __lying __ knees bent __no movement __movement __support __sleeping __exercise __morning __afternoon __evening

What have you done to relieve the symptoms: (check all that apply)
__ Prescription Medication __ Over the counter drugs
__ Homeopathic remedies __ Physical Therapy
__ Surgery __ Acupuncture __ Chiropractic
__ Massage __ Ice __ Heat __ Other

*What should we know about your current condition: _____

Location of symptom #1 (use a body diagram and a Problem Sheet for each Problem)

***Please use a red (or different color) pen to especially mark all SCARS, surgeries or trauma on this diagram 1 along with your Problem #1**



Patient Name:_____ DOB: ___/____/_____

Problem #2 - Use a Body diagram and a Problem Sheet for each Problem

***Describe your problem #2:** _____

*On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
(0 = no pain; 1-3 = aware of pain, but can carry on activities of daily routine; 4-7 = intermittent/certain motions produce pain; 8-10 = constant, severe, nothing makes it better without drugs).

***How did your problem begin:** _____

*__Onset date of problem:__ _____

How often do you experience symptoms: _____

What is the nature of your symptoms: (check all that apply)
__ Dull __ Sharp __ Throbbing __ Burning __ Deep
__ Aching __ Tingling __ Stabbing __ Cramping
__ Numbness __ Radiating

Does it affect other areas of your body: __ Yes __ No

To what areas does the pain radiate, shoot or travel: _____

***What makes it worse:** __sitting __standing ___walking __bending __stooping__ looking up __looking down __movement __climbing stairs __lying supine __lying prone __reaching __sneezing __sleeping __twisting __lifting __exercise __rest __ driving __typing __morning __afternoon __evening

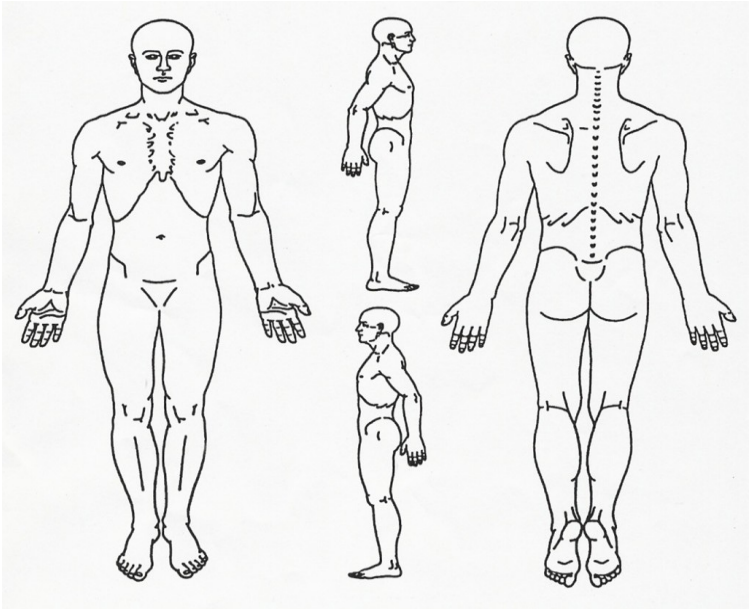
Comments:
_____
_____
_____
_____

What makes it better: __ sitting __lying __ knees bent __no movement __movement __support __sleeping __exercise __morning __afternoon __evening

What have you done to relieve the symptoms: (check all that apply)
__ Prescription Medication __ Over the counter drugs
__ Homeopathic remedies __ Physical Therapy
__ Surgery __ Acupuncture __ Chiropractic
__ Massage __ Ice __ Heat __ Other

*What should we know about your current condition: _____

Location of symptom #2:



Patient Name:_____ DOB: ___/____/_____

Problem #3 -

***Describe your problem #3:** _____

*On a scale of 0-10 , rate the intensity: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
(0 = no pain; 1-3 = aware of pain, but can carry on activities of daily routine; 4-7 = intermittent/certain motions produce pain; 8-10 = constant, severe, nothing makes it better without drugs).

*How did your problem begin: _____

*Onset date of problem: _____

How often do you experience symptoms: _____

What is the nature of your symptoms: __ Dull __ Sharp __ Throbbing __ Burning __ Deep
(check all that apply) __ Aching __ Tingling __ Stabbing __ Cramping
__ Numbness __ Radiating

Does it affect other areas of your body: __ Yes __ No

To what areas does the pain radiate, shoot or travel: _____

***What makes it worse:** __sitting __standing ___walking __bending __stooping__ looking up __looking down __movement __climbing stairs __lying supine __lying prone __reaching __sneezing __sleeping __twisting __lifting __exercise __rest __ driving __typing __morning __afternoon __evening

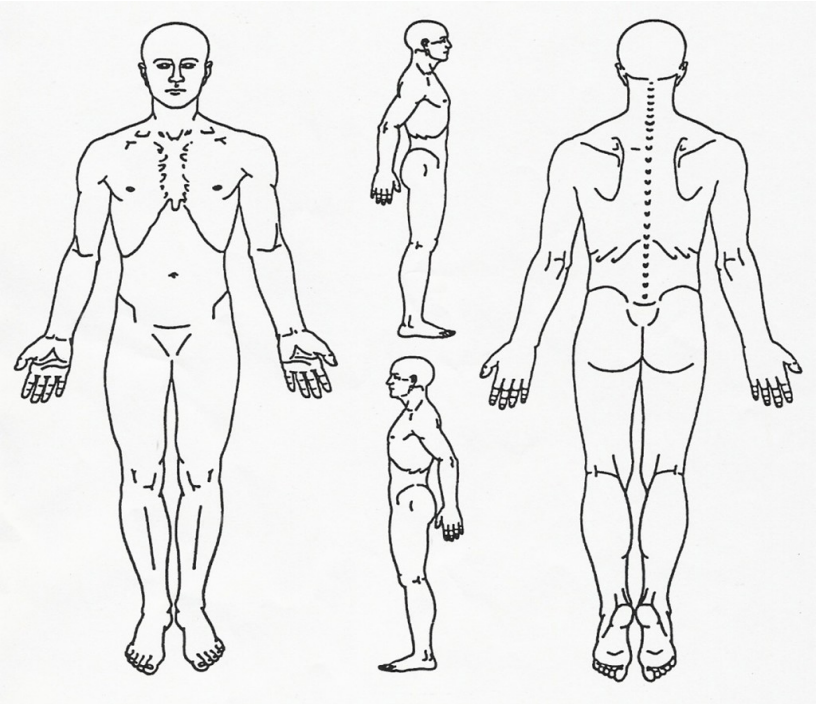
Comments:
_____
_____
_____
_____

What makes it better: __ sitting __lying __ knees bent __no movement __movement __support __sleeping __exercise __morning __afternoon __evening

What have you done to relieve the symptoms: __ Prescription Medication __ Over the counter drugs
(check all that apply) __ Homeopathic remedies __ Physical Therapy
__ Surgery __ Acupuncture __ Chiropractic
__ Massage __ Ice __ Heat __ Other

*What should we know about your current condition: _____

Location of Symptom #3:



Patient Name:___________________________________ DOB: ___/____/__________

Medications

* Denotes required information *** PRINT CLEARLY ***

***Name:** ____________________
***Dosage:** (ie., mg/mcg) Quantity: Frequency:
***Start Date:** ____________________
Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

***Name:** ____________________
***Dosage**: (ie., mg/mcg) Quantity: Frequency:
***Start Date:** ____________________
Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

***Name:** ____________________
***Dosage:** (ie., mg/mcg) Quantity: Frequency:
***Start Date:** ____________________
Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

***Name:** ____________________
***Dosage:** (ie., mg/mcg) Quantity: Frequency:
***Start Date:** ____________________
Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

***Name:** ____________________
***Dosage:** (ie., mg/mcg) Quantity: Frequency:
***Start Date:** ____________________
Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

***Name:** ____________________
***Dosage:** (ie., mg/mcg) Quantity: Frequency:
***Start Date**: ____________________
Obtained: __ Over the counter __ By prescription
Prescribed by: ____________________
Comments: ____________________

Patient Name:___________________________________ DOB: ___/____/__________

Nutritional Supplements

* Denotes required information

*Name: ____________________
*Start Date: ____________________
Manufacturer: ____________________
Quantity: ____________________
Frequency: ____________________
Taken with water: __ Yes __ No Taken with food: __Yes __No
Reason for taking: ____________________
Comments: ____________________

*Name: ____________________
*Start Date: ____________________
Manufacturer: ____________________
Quantity: ____________________
Frequency: ____________________
Taken with water: __ Yes __ No Taken with food: __Yes __No
Reason for taking: ____________________
Comments: ____________________

*Name: ____________________
*Start Date: ____________________
Manufacturer: ____________________
Quantity: ____________________
Frequency: ____________________
Taken with water: __ Yes __ No Taken with food: __Yes __No
Reason for taking: ____________________
Comments: ____________________

*Name: ____________________
*Start Date: ____________________
Manufacturer: ____________________
Quantity: ____________________
Frequency: ____________________
Taken with water: __ Yes __ No Taken with food: __Yes __No
Reason for taking: ____________________
Comments: ____________________

*Name: ____________________
*Start Date: ____________________
Manufacturer: ____________________
Quantity: ____________________
Frequency: ____________________
Taken with water: __ Yes __ No Taken with food: __Yes __No
Reason for taking: ____________________
Comments: ____________________

Patient Name:_____ DOB: ___/____/_____

Allergies

* Denotes required information *** PRINT CLEARLY ***

***Name:** _____
***Medication Related** __ Yes __ No
***Reaction:** _____
***Onset Date:** _____
Comments: _____

***Name:** _____
***Medication Related** __ Yes __ No
***Reaction:** _____
***Onset Date:** _____
Comments: _____

Personal Medical History

Illnesses

Illness: _____ Illness: _____
Start date: _____ Start date: _____
End date: _____ End date: _____

Illness: _____ Illness: _____
Start date: _____ Start date: _____
End date: _____ End date: _____

Surgeries

Surgery: _____ Surgery: _____
Date: _____ Date: _____
__ In patient ___Out Patient __ In patient ___Out Patient
Surgery: _____ Surgery: _____
Date: _____ Date: _____
__ In patient ___Out Patient __ In patient ___Out Patient

Hospitalizations

Reason: _____ Reason: _____
Date: _____ Date: _____
Duration: _____ Duration: _____

Reason: _____ Reason: _____
Date: _____ Date: _____
Duration: _____ Duration: _____

Patient Name:_____ DOB: ___/____/_____

Injuries **(Include broken bones, blows to head, and loss of consciousness)**

Injury: _____ Injury: _____
Date: _____ Date: _____

Injury: _____ Injury: _____
Date: _____ Date: _____

Injury: _____ Injury: _____
Date: _____ Date: _____

Have you ever been treated by a *chiropractor* before? ☐Yes ☐No. If yes when was the last time ___/___/_____

Do you have a preferred chiropractic technique? ☐Yes ☐No. Describe: _____

Age when you first experienced spinal (back, neck) problems:_____ yrs.

Have you had **X-rays MRI/CAT scan** taken of the following: ☐Back ☐Neck ☐Chest ☐Other _____

Last ☐**X-ray**, ☐**MRI**, ☐**CAT scan**, Date or **Year** __/ __/_____ Reason: _____

Family Medical History: Identify any conditions that you, or any of your family members have now or have had in the past: (M = Mother, F = Father, B = Brother, S= Sister, D= Daughter, SN = Son, G = Grandparent, **X = Self; Indicate "Date of Onset" for Self)** Date/Year of onset is ONLY for "self"

_____Alcoholism

_____Anemia

____ Autism (psychological disorder)
____Depression ____ ADDH
____ Anxiety

_____Deep vein thrombosis (clotting disorder)

_____Cancer (specify type of cancer)
Type:_____

_____Cold sores

_____ COPD (Lung Disease)
_____Asthma _____ Chronic Bronchitis
_____Emphysema ____Pneumonia

___ Dementia or Alzheimer's

_____Diabetes (circle which one:Type1, Type 2, or pre-diabetes)

_____Epilepsy

_____Eczema

_____Goiter

_____HIV/AIDS

_____High Blood Pressure

_____Hypertension

____ Kidney Disease

_____Mumps
_____Polio

_____Rheumatic fever

_____ Heart Attack

_____ Deep Vein Thrombosis (clotting disorder)

_____Septicemia (bacteremia or blood poisoning)

_____Sudden Infant Death Syndrome

_____Tuberculosis

_____Ulcer(s)

____ Osteoporosis

____Detached retina

____ High Cholesterol
_____Stroke ____Brain Attack

_____Gastrointestinal Disorder (colon polyp, Crohn's disease, irritable bowel syndrome)

Patient Name:_____ DOB: ___/____/_____

Review of Body Systems

Musculoskeletal __ No issues Onset Year

Osteoporosis:	__ Have __ Had _____Onset	Arthritis:	__ Have __ Had _____Onset
Scoliosis:	__ Have __ Had _____Onset	Neck Pain:	__ Have __ Had _____Onset
Back Problems	__ Have __ Had _____Onset	Hip Disorders	__ Have __ Had _____Onset
Knee injuries:	__ Have __ Had _____Onset	Foot/ankle pain:	__ Have __ Had _____Onset
Shoulder Problem:	__ Have __ Had _____Onset	Elbow/Wrist Pain:	__ Have __ Had _____Onset
TMJ Issues:	__ Have __ Had _____Onset	Poor Posture:	__ Have __ Had _____Onset

Neurological __ No issues Onset Year

Anxiety:	__ Have __ Had _____Onset	Depression:	__ Have __ Had _____Onset
Headaches:	__ Have __ Had _____Onset	Dizziness:	__ Have __ Had _____Onset
Pins & needles:	__ Have __ Had _____Onset	Numbness:	__ Have __ Had _____Onset

Cardiovascular __ No issues Onset Year

High Blood Pressure:	__ Have __ Had _____Onset	Low Blood Pressure:	__ Have __ Had _____Onset
High cholesterol:	__ Have __ Had _____Onset	Poor circulation:	__ Have __ Had _____Onset
Angina:	__ Have __ Had _____Onset	Excessive bruising:	__ Have __ Had _____Onset

Respiratory __ No issues Onset Year

Asthma:	__ Have __ Had _____Onset	Apnea:	__ Have __ Had _____Onset
Emphysema:	__ Have __ Had _____Onset	Hay fever:	__ Have __ Had _____Onset
Shortness of breath:	__ Have __ Had _____Onset	Pneumonia:	__ Have __ Had _____Onset

Digestive __ No issues Onset Year

Anorexia/bulimia:	__ Have __ Had _____Onset	Ulcer:	__ Have __ Had _____Onset
Food sensitivities:	__ Have __ Had _____Onset	Heartburn:	__ Have __ Had _____Onset
Constipation:	__ Have __ Had _____Onset	Diarrhea:	__ Have __ Had _____Onset

Sensory __ No issues Onset Year

Blurred vision:	__ Have __ Had _____Onset	Ringing in ears:	__ Have __ Had _____Onset
Hearing loss:	__ Have __ Had _____Onset	Chronic ear infection:	__ Have __ Had _____Onset
Loss of smell:	__ Have __ Had _____Onset	Loss of taste:	__ Have __ Had _____Onset

Integumentary __ No issues Onset Year

Skin cancer:	__ Have __ Had _____Onset	Psoriasis:	__ Have __ Had _____Onset
Eczema:	__ Have __ Had _____Onset	Acne:	__ Have __ Had _____Onset
Hair loss:	__ Have __ Had _____Onset	Rash:	__ Have __ Had _____Onset
			__ Have __ Had _____Onset

Endocrine __ No issues Onset Year

Thyroid issues:	__ Have __ Had _____Onset	Immune disorders:	__ Have __ Had _____Onset
Hypoglycemia:	__ Have __ Had _____Onset	Frequent infection:	__ Have __ Had _____Onset
Swollen glands:	__ Have __ Had _____Onset	Low energy:	__ Have __ Had _____Onset

Genitourinary __ No issues Onset Year

Kidney stones:	__ Have __ Had _____Onset	Infertility:	__ Have __ Had _____Onset
Bedwetting:	__ Have __ Had _____Onset	Prostate issues:	__ Have __ Had _____Onset
Erectile dysfunction:	__ Have __ Had _____Onset	PMS symptoms:	__ Have __ Had _____Onset

Constitutional __ No issues Onset Year

Fainting:	__ Have __ Had _____Onset	Low libido:	__ Have __ Had _____Onset
Poor appetite:	__ Have __ Had _____Onset	Fatigue:	__ Have __ Had _____Onset
Sudden weight gain/loss:	__ Have __ Had _____Onset	Weakness:	__ Have __ Had _____Onset

Patient Name:_____ DOB: ___/____/_____

Smoking History

* Denotes required information

* Have you ever been a smoker: __Yes __No

*Do you currently smoke: __ Yes __ No
Years smoked: _____
Packs a day: _____
Interest in quitting on a scale of 0-10: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
How long since you stopped: _____

Social History

* Denotes required information

Consumption

How much alcohol do you drink daily: _____
If you drink, what is alcoholic drink choice: _____
How many cups of coffee do you drink daily: _____
What do you put in your coffee: _____
How much soda pop do you drink daily: _____
If you drink soda pop, what type soda: _____
How much water do you drink daily: _____
What kind/source is your water: _____
How much do you depend on pain relievers: _____
Do you use recreational drugs: __ Yes __ No

Stress Information

*How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot
*How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot
What are the major stressors in your life: _____

Sleeping Information

How many hours do you sleep per night: _____
What is your preferred sleeping position: _____
What type of mattress & pillow do you have: _____
How old are your mattress & pillow: _____

Healthy Eating & Exercise Information

What have you eaten/drank in last 24 hours: _____
How much regular exercise do you perform: _____
*Rate your healthy eating habits: Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy
Typical eating habits: __ Skip Breakfast __ 2 meals per day __ 3 meals per day
__ Snacking between meals

What would be the most significant thing that would improve your health:

_____

_____

What additional health goals do you have:

_____

Patient Name:_____ DOB: ___/____/_____

Daily Activities

* Denotes required information

Rate the "Current" difficulty and the "Prior" Difficulty of the following daily activities on a scale of 0-10 (0 being easiest, 10 most difficult):

Activity	*Current Difficulty	*Prior Difficulty
Bending:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Carrying:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Driving:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Housework:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Lying:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Opening jars:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Personal care:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Picking up objects:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Pulling:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Pushing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reaching:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reaching behind:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Reading:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Recreation:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Running:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Shopping:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sit to stand:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sitting:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sleeping:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Standing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Throwing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Walking:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Writing:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Comments: _____

Patient Name:_____ DOB: ___/____/_____

To answer YES to the questions below, put a circle around the YES.
To answer NO to these question, put a circle around the No.
Please answer all questions. If you are not sure, guess.

Do you sweat or tremble a lot during examinations or questioning?	Yes	No		Was anyone in your family ever a patient in a mental hospital (for their nerves)?	Yes	No
Do you get nervous and shaky when approached by a superior?	Yes	No		Are you extremely shy or sensitive?	Yes	No
Does your work fall to pieces when the boss or a superior is watching you?	Yes	No		Do you come from a shy or sensitive family?	Yes	No
Does your thinking get completely mixed up when you have to do things quickly?	Yes	No		Are your feelings easily hurt?	Yes	No
Must you do things very slowly in order to do them without mistakes?	Yes	No		Does criticism always upset you?	Yes	No
Do you always get directions and orders wrong?	Yes	No		Are you considered a touchy person?	Yes	No
Do strange people or places make you afraid?	Yes	No		Do people usually misunderstand you?	Yes	No
Are you scared to be alone when there are not friends near you?	Yes	No		Do you have to be on your guard even with friends?	Yes	No
Is it always hard for you to make up your mind?	Yes	No		Do you always do things on sudden impulse?	Yes	No
Do you wish you always had someone at your side to advise you?	Yes	No		Are you easily upset or irritated?	Yes	No
Are you considered a clumsy person?	Yes	No		Do you go to pieces if you don't constantly control yourself?	Yes	No
Does it bother you to eat anywhere except in your own home?	Yes	No		Do little annoyances get on your nerves and make you angry?	Yes	No
Do you feel alone and sad at a party?	Yes	No		Does it make you angry to have anyone tell you what to do?	Yes	No
Do you usually feel unhappy and depressed?	Yes	No		Do people often annoy and irritate you?	Yes	No
Do you often cry?	Yes	No		Do you flare up in anger if you can't have what you want right away?	Yes	No
Are you always miserable and blue?	Yes	No		Do you often get into a violent rage?	Yes	No
Does life look entirely hopeless?	Yes	No		Do you often shake or tremble?	Yes	No
Do you often wish you were dead and away from it all?.	Yes	No		Are you constantly keyed up and jittery	Yes	No
Does worrying continually get you down?	Yes	No		Do sudden noises make you jump or shake badly?	Yes	No
Does worrying run in your family?	Yes	No		Do you tremble or feel weak whenever someone shouts at you?	Yes	No
Does every little thing get on your nerves and wear you out?	Yes	No		Do you become scared at sudden movements or noises at night?	Yes	No
Are you considered a nervous person?	Yes	No		Are you often awakened out of your sleep by frightening dreams?	Yes	No
Does nervousness run In your family?.	Yes	No		Do frightening thoughts keep coming back into your mind?	Yes	No
Did you ever have a nervous breakdown?	Yes	No		Do you often become suddenly scared for no good reason?	Yes	No
Did anyone in your family ever have a nervous breakdown?	Yes	No		Do you often break out in a cold sweat?	Yes	No
Were you ever a patient in a mental hospital (for your nerves)?	Yes	No				

Patient Name:_____ DOB: ___/____/_____

Acknowledgements

Chiropractic care:	☐	I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.
Privacy Verification:	☐	I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Permission to contact:	☐	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
Payment Verification:	☐	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
X-ray Verification: *(females only)*	☐	I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks. Date of last menstrual period: _____
General Verification:	☐	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-ray. The particular diagnosis and treatment plan for my case have been explained to me.

I understand that the practice of chiropractic is not an exact science, that individuals respond differently to treatment, and that there are no guarantees of the result of any treatment. I understand that the examination and treatment involves certain risks and those risks have been explained or provided to me. I do not expect the doctor to be able to anticipate and explain all imaginable risks and/or contraindications, and I wish to rely on the doctor to exercise his judgment based on the facts known to be in my best interest during the course of my treatment. I understand that the doctor is a licensed chiropractor in the state of Texas and by such is licensed to employ objective or subjective means without the use of drugs, surgery, x-ray therapy or radium therapy for the purpose of ascertaining the alignment of the vertebrae, other joints and/or injured neuro-musculoskeletal structures to correct any subluxation, misalignment or impairment. Accordingly, I understand the practice of chiropractic is limited to diagnosing and re-adjusting the spinal vertebrae and/or extremity when they are misaligned, in order to help cure or resolve neuro-musculoskeletal symptoms that result from such a misalignment.

I understand any and all doctors employed by this office disclaim being able to treat me for any maladies or symptoms that I may be experiencing that may not be related to the injuries reported to the doctor. It is not expressed or implied in this office that the treatments offered by the doctor will specifically cure any symptoms I may be experiencing in any other part of my body.

I have read and understood the above consent for chiropractic treatments and care. I have also had the opportunity to ask questions regarding this consent and my treatment plan. Further, I understand all charges incurred at Health By Hands are ultimately my responsibility regardless of payment availability from another source. I am also aware that there is a missed appointment/cancellation policy: a variable non-refundable fee (consistent with the length of time scheduled for the visit) will be charged for each missed appointment or a cancellation that has not been received at least 24 hours prior to my appointment.

Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation. I therefore authorize examination and treatment to be performed at Health by Hands.

PATIENT'S NAME: (PLEASE PRINT)_____

PATIENT'S SIGNATURE:_____DATE ____/____/_____

Or NAME OF CUSTODIAL PARENT OR LEGAL GUARDIAN, ON BEHALF OF THE PATIENT:

(PLEASE PRINT)_____

PARENT / GUARDIAN SIGNATURE:_____DATE ____/____/_____

Patient Name:_____ DOB: ___/____/_____

NOTICES OF PRIVACY PRACTICES

(Effective April, 2003) **[Notice of Privacy, Page 1 of 2]**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, ALSO HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your health record

A record is made each time you are treated at our Clinic. Your injuries, evaluation, test results, diagnosis, treatment, and a plan of care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure it's accuracy, and enable you to relate to who, what, when, where and why others may be allowed access to you health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. This Clinic is not required to accept your requests and you cannot request restrictions on uses or disclosures otherwise required by law. Your rights include being able to review or obtain a paper copy of your health information, and are given an account of all disclosures. You may also request communication of your health information be made by alternative means or to alternative locations in a confidential manner. This Clinic is required by law to accommodate reasonable request to receive communications of health information by alternative means or to alternative locations if you clearly state that disclosures of all or part of the information that could endanger you. This Clinic may require you to submit a written request for any of the documents or actions that you have a right to under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Our responsibilities

This Clinic is required by law to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with the respect to the information we collect and maintain about you. This Clinic is required to abide by the terms of this notice, as currently in effect, and to notify you if we are unable to grant your requested restrictions or locations. This Clinic reserves the right to change its practices and effect the new provisions with respect to all health information that it maintains (including such information that this Clinic had prior implementation of the new provisions).

Use and disclosure of your Health Information without your authorization

This Clinic may use and disclose your health information in order to provide 'Treatment", obtain "Payment" and perform our "Health Care Operations", as well as other specific reasons detailed below:

- **Treatment** — information obtained by your provider in this Clinic will be recorded in your medical record and used to determine the course of treatment. This consists of you provider recording his/her own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as physicians.

- **Payment** — Your health care information will be used in order to receive payment for services rendered by this Clinic. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

- **Health Care Operations** — The medical staff in this Clinic will use your health information to assess the care you received and the outcome of your cases compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

- **Business Associates** — Some or all of your health information may be subject to disclosure through contracts for services to assist this Clinic in proving health care. To protect your health information, we require these Business Associates to follow the same standards held by this Clinic through the terms detailed in a written agreement.

- **Notification** — Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.

- **Communications with Family** — Using best judgment, a family member, or close personal friend, identified by you, may be given health information relevant to your care and/or recovery.

- **Worker's Compensation** — This Clinic will release information to the extent authorized by law in matters of worker's compensation.

- **Public Health** — This clinic is required by law to disclose your health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This Clinic is further required by law to report communicable diseases, injury, or disability.

• **Law Enforcement** — This Clinic may disclose your health information to the police or other law enforcement officials as required or permitted under state law or in response to a valid court, grand jury, or administrative subpoena.

• **Health Oversight Activities** — This Clinic may disclose your health information to a health oversight agency that overseas the health care system and is charged with responsibility for ensuring compliance with rules of government health programs, such as Medicare and Medicaid.

• **Victims of Abuse, Neglect, or Domestic Violence** — If this Clinic reasonably believes that you are a victim of abuse, neglect, or domestic violence, it may disclose your health information to the appropriate governmental authority, authorized by law to receive reports such as abuse, neglect, or domestic violence.

• **Judicial and Administrative Proceedings** — This Clinic may disclose your health information in the course of a judicial proceeding in response to a legal order or other lawful purpose.

• **As required by Law** — This clinic may use and disclose your health information when required to do so by any other law not already referred to in the proceeding categories.

Use or disclosure of your health information with written authorization

Any other use or disclosure of your health information, other than those listed above, will only be made with your written authorization. You may revoke your authorization at any time, except to the extent this Clinic used or disclosed your health information in reliance of your authorization.

To receive additional information or report a problem

For further explanation of this notice or any complaints about your Privacy rights, or how Chiropractic Health and Fitness has handled your health information please contact us at 817-640-0282. If nobody is available to answer your concerns please feel free to make an appointment for a personal conference in person or by phone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue. S.W.
Room 509F HHH Building
Washington. DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____
Patient's Name (print) Parent's / Legal Guardian's Name (print)

_____ _____
Patient's / Legal Guardian's Signature Date

_____ _____
Authorized Facility Signature Date Date

HEALTH BY HANDS WELLNESS CENTER
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FAX 817-451-1252