Patient Contact Information

Title:	Last name:	Middle:	First:	Nickname:
Spouse's Name:	Do you have children? ☐ Yes ☐ No Ages of Children: _____			
Address:		City:	State:	Zip:
Primary Phone:	Secondary Phone:		Mobile Phone:	
Sex : Male / Female	Date of Birth:		Social Security #:	
Email Address:				
Employment (circle one) Employed Student P/T Student F/T Other Retired Self Employed	Occupation:		Employer:	
Marital status (circle one): Mar / Single / Other	Referred By:		Other family members seen here:	

CONFIDENTIALITY QUESTIONNAIRE

In Order to comply with HIPPA guidelines (effective 4-12-03), it is necessary for you to complete the following information:

Who may we inform about your general medical condition, diagnosis, test results or treatment plan? This includes, but is not limited to general questions about your condition.

Name:	Relation:	Phone:

May we leave confidential (billing/medical condition/missed appointment) messages on:

Your Primary Phone? YES NO

Your Secondary Phone? YES NO

Your Mobile Phone? YES NO

Your Email? YES NO

Would you like to receive updates and messages/alerts via e-mail? YES NO

Would you like us to send reports and updates to your Primary Care Physician? YES NO

If Yes: Name: _____

Would you like us to send reports and updates to your Referring Physician? YES NO

If Yes: Name: _____

I understand that this consent will remain in effect until revoked IN WRITING by myself, or my legal guardian/parent.

_____ _____ _____

Signature **Date** **Relationship**

***********PLEASE NOTE************

If you fail to notify our office **in writing** that you would like to have an individual removed from any of the above, that person **will** be able to obtain information about you from our office.

Medical History for (patient's name):

Name of your family Doctor/Primary Care Physician:

What city and state?

Date of last Visit: / / / | Date of last exam: / / /

Past Surgeries:

Current Condition

The reason for your office visit today:

Have you been treated by a Medical Physician for the current condition? ☐ Yes ☐ No

If Yes: Who, When and Where?

Chiropractic Treatment History:

-Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No

-If Yes: Who, When, and Where? _____

_____

-Was it for the current condition? ☐ Yes ☐ No

Patient's Current or Past Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other Patient Conditions:

Current Medications:

Family History of Illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitis

Type of Cancer(s):

Other Family Conditions:

Patient Medical History, Continued

Social History:	
Alcohol Consumption? □ Yes □ No Coffee Consumption? □ Yes □ No Soda Consumption? □ Yes □ No Recreational Drug Use? □ Yes □ No	**Major Stressors:**
Daily Water Consumption: _____ Daily Sleep Amount: _____hours Healthy Eating Rank? _____ (0-poor, 10 excellent) Do you currently exercise? □ Yes □ No Exercise Frequency: ____hours/day for ____ days/week	**Things to Improve:** **Other Health Goals:**

Smoking/Tobacco History	
Current Smoker? □ Yes □ No Former Smoker? □ Yes □ No Smoking Start Date: _____ Smoking End Date: _____ Packs Per Day? _____ Tobacco User? □ Yes □ No	**Comments on Smoking and/or Tobacco Usage?**

Other Comments on Medical History:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

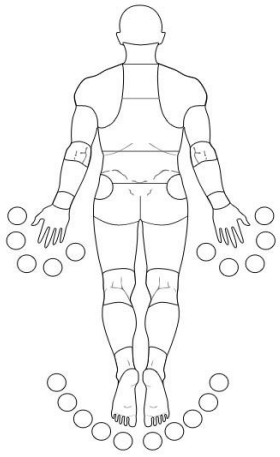
Patient Name (Printed): _____

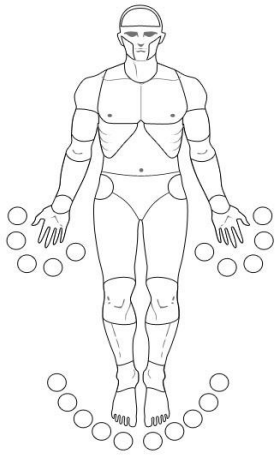
Patient Signature: _____ Date:_____

Current Complaints

Patient's Name: _____ Date: _____

Please describe your current complaints by marking the image and providing details using the sections below. If you have more than one region of complaints, please request additional sheets.





Office Use Only:	
Hgt:	in
Wgt	lbs
BP____/_____	mm Hg
Pulse:	bpm
Right Handed / Left Handed	
Outcome Assessments:	
NECK	BACK
LEFS	UEFI

Area(s) of Complaint:				
Pain / Symptom Intensity:	**0 (None) 1 2 3 4 5 6 7 8 9 10 (Excruciating) N/A**			
Cause Of Injury:				
When and how did the condition begin?				
Frequency (How Often?)	Infrequent < 25%	Occasional 25%-50%	Frequent 50% - 75%	Constant > 75%
Duration: How long?	____Days / weeks / months / year(s)			

When does it seem to be at its worse? (Timing)

☐ Morning ☐ Midday ☐ End of Day ☐ Throughout the day ☐ Night with Pain
During / After - ☐ Light ☐ Moderate ☐ Strenuous - Activities

Would you describe the pain as radiating/shooting?, If so where?

☐ Yes ☐ No

The symptoms are described as: (Quality)

Dull	Sharp	Throbbing	Burning	Deep	Aching
Tingling	Stabbing	Cramping	Numbness	Radiating	

What makes it worse (Aggravating Factors)?

Sitting	Standing	Walking	Bending	Stooping	Lifting
Sleeping	Sneezing	Coughing	Straining	Reaching	Twisting
Looking Up	Looking Down	Movement	Rest	Lying Supine	Driving
Typing	Scooping	House Chores	Exercise	Lying Prone	Stair Stepping

What makes it better? (Relieving Factors)

Sitting	Standing	Lying	Knees bent up	Support
No Movement	Movement	Heat	Ice	Analgesic Topical
Ibuprofen	Medication	Rest	Stretching/Exercise	Adjustments

Comments:_____

_____

X _____

Patient's Signature

2100 NASA Parkway, Suite 100 ● Seabrook, Texas 77586 ● 281-942-9011 ● 281-291-8899

ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Premier Sports Chiropractic, PLLC "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Premier Sports Chiropractic, PLLC's Notice of Privacy Practices prior to signing this document. Premier Sports Chiropractic, PLLC's Notice of Privacy Practices has been provided to me. 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 Premier Sports Chiropractic, PLLC. The Notice of Privacy Practices for Dustin Young Chiropractic is also provided on request at the front desk of this practice and on Premier Sports Chiropractic, PLLC website at www.dustinyoungdc.com This Notice of Privacy Practices also describes my rights and Premier Sports Chiropractic, PLLC's duties with respect to my protected health information.

Premier Sports Chiropractic, PLLC 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 accessing Premier Sports Chiropractic, PLLC website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

INITIAL HERE: ☐

Consent to Treat

Chiropractic examination (history, examination, and x-rays) and therapeutic procedures (including but not limited to spinal and/or extremity adjustments, heat/cold application, mechanical traction, acupuncture, manual muscle therapy, electrical muscle stimulation, therapeutic ultrasound, and therapeutic exercises) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of Premier Sports Chiropractic, PLLC, to inform the patients about them. Additional diagnostics such as advanced imaging, laboratory tests and/or outside medical referral may also be ordered as needed.

Complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, and temporary worsening of symptoms. More serious complications such as fractures and stroke are extremely rare. Additional information on side effects and complications can be explained by your treating doctor upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required.

I consent to the provisions of care. I understand that this care may include treatment, special tests, exams, evaluations, and rehabilitation. I understand that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist in providing care. This may include any staff members or interns of Premier Sports Chiropractic, PLLC.

This authorization shall remain effective unless revoked in writing by the undersigned.

INITIAL HERE: ☐

2100 NASA Parkway, Suite 100 ● Seabrook, Texas 77586 ● 281-942-9011 ● 281-291-8899

Consent to Treatment
(Minors)

I hereby request and authorize Premier Sports Chiropractic, PLLC to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office. INITIAL

X-Ray Consent

I consent to those diagnostic x-ray procedure(s) my referring doctor may consider necessary in the course of my health case. I understand the nature and purposes of these procedure(s) and the risks involved, as well as the consequences of not consenting to the procedures.

Female Patient Only
Some X-Ray and CT examinations may expose the uterus. In order to avoid any unnecessary fetal exposure in the event of pregnancy, the 10 days immediately following the onset of the menstrual period are generally considered the safest for x-ray examinations.

Onset of last menstrual period		Date	Today's Date
I am post menopausal	Yes	No	Don't Know
I am Pregnant	Yes	No	Don't Know
I have had a hysterectomy	Yes	No	Don't Know
I use an IUD	Yes	No	Don't Know

I recognize that if I am pregnant and have radiation, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my doctor feels the information to be gained from this examination is important to my health. I therefore wish to have this x-ray examination performed at this time.

Patient or Parent/Guardian's Signature: _____ **Date:** _____

Parent/Guardian Name/Relationship: _____