

Patient Contact Information

Title:	Last name:	Middle:	First:	Nickname:
Spouse's Name:		Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ages: _____
Address:			City:	State: _____ Zip: _____
Primary Phone:		Secondary Phone:		Mobile Phone:
Sex :	Male / Female	Date of Birth:		
Home email:			Work email:	
<i>Employment (circle one)</i> Employed Student P/T Student F/T Other Retired Self Employed		Occupation:		Employer:
<i>Marital status (circle one)</i> Single / Mar			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 Work email? YES NO

Your Home 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.

Patient Medical History

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 this visit:		
	When did this condition begin? / /	Is this condition getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No	The pain/discomfort... <input type="checkbox"/> is constant <input type="checkbox"/> comes & goes
	Have you been treated by a Medical Physician <u>for this condition</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who, when & where? _____		

Have you ever been treated by a Chiropractor before? Yes No Was it for the current condition? Yes No
If so, who, when & where? _____

Present/Past Illness /Conditions:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	<input type="checkbox"/>
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/>

Other: _____

Current Medications: _____

Family History of Illness:					
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis

Other: _____

Type of Cancer: _____

Patient Name (Printed): _____

Patient Medical History, Continued

Social History:		
Alcohol Consumption? <input type="checkbox"/> Yes <input type="checkbox"/> No ___drinks/week Coffee Consumption? <input type="checkbox"/> Yes <input type="checkbox"/> No ___drinks/week Soda pop Consumption? <input type="checkbox"/> Yes <input type="checkbox"/> No ___drinks/week Water Consumption: _____drinks/week	Sleep Amount? _____hours/night Pain Relievers? <input type="checkbox"/> Yes <input type="checkbox"/> No ___#per day Recreational Drug Use? <input type="checkbox"/> Yes <input type="checkbox"/> No Healthy Eating? <input type="checkbox"/> Yes <input type="checkbox"/> No	Exercise Frequency: _____hours/day Physical Stress level? 0(none)-10(extreme) _____ Emotional Stress Level? 0(none)-10(extreme) _____

Major Stressors:	Things to Improve:	Other Health Goals:

Smoking History	
Currently Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Years Smoked? _____years Packs Per Day? _____ Level of Interest in Quitting 0 (none)- 10 (extreme) _____	Comments on Smoking?

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

Patient Name (Printed): _____

Patient Signature: _____

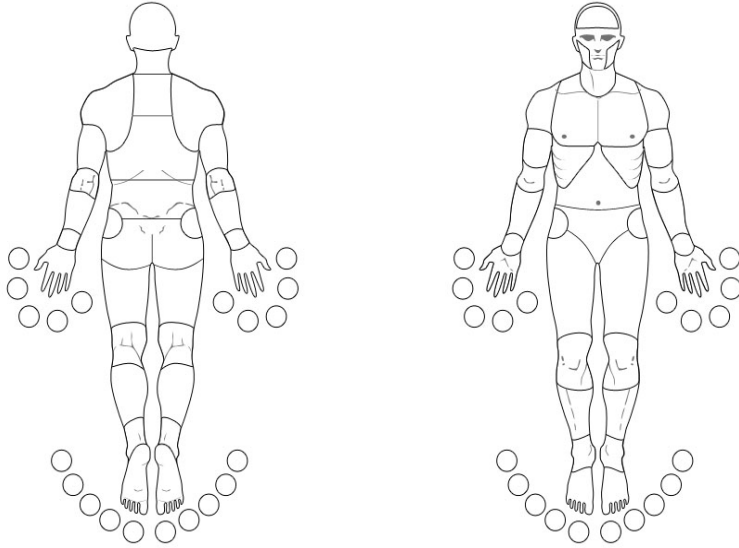
Date: _____

Current Complaints

Patient's Name: _____

Date: _____

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below. If you have more than one region of complaints, use additional sheets.



Office Use Only	
Hgt: " _____	Respiration: bpm _____
Wgt lbs _____	BP _____ / _____ mm Hg
BMI _____	Temperature F _____
Pulse: bpm _____	Right / Left Handed _____
Regional Assessment	
NECK _____	BACK _____
LEFS _____	DASH _____

Area(s) of Complaint					
Pain / Symptom Intensity:	0 (None) 1 2 3 4 5 6 7 8 9 10 (Excruciating) N/A				
Mechanism Of Injury:					
Onset, 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, years over the past _____ days, weeks, months, year(s)				
When does it seem to be at its worse? (Timing)					
<input type="checkbox"/> Morning <input type="checkbox"/> Midday <input type="checkbox"/> End of Day <input type="checkbox"/> Throughout the day <input type="checkbox"/> Night with Pain During / After - <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous - Activities					
Would you describe the pain as radiating/shooting?, If so where?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
This 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	
Ibuprophen	Medication	Rest	Stretching/Exercise	Adjustments	

Comments: _____

 Patient's Signature

Gateway Chiropractic – South Shore, PLLC

3033 Marina Bay Drive, Suite 200 ■ League City, Texas 77573
(Tel) 281-334-9300 (Fax) 281-334-9301

ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Gateway Chiropractic - South Shore, PLLC “Notice of Privacy Practices” has been provided to me.

I understand I have a right to review Gateway Chiropractic’s Notice of Privacy Practices prior to signing this document. Gateway Chiropractic’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 Gateway Chiropractic. The Notice of Privacy Practices for Gateway Chiropractic is also provided on request at the front desk of this practice and on Gateway Chiropractic’s website at www.gatewaychiropractic.com. This Notice of Privacy Practices also describes my rights and Gateway Chiropractic’s duties with respect to my protected health information.

Gateway Chiropractic 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 Gateway Chiropractic’s 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

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 Gateway Chiropractic, 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 Gateway Chiropractic..

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

initial

Gateway Chiropractic – South Shore, PLLC

3033 Marina Bay Drive, Suite 200 ■ League City, Texas 77573

(Tel) 281-334-9300 (Fax) 281-334-9301

Consent to Acupuncture Treatment

I consent to being treated with acupuncture needle procedures as part of the chiropractic care rendered to me by Gateway Chiropractic. I have been informed of the potential risks of the procedures, which are similar to those of an injection procedure or needle immunization procedure.

I understand that only sterile packaged single use needles will be used and that standard clean needle technique will be followed. The procedures have been explained to me and I understand them to my satisfaction.

initial

Consent to Treatment (Minor)

I hereby request and authorize Gateway Chiropractic 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/Guardian: _____ Date: _____

Witness: _____ Relationship: _____