Date:_____

PATIENT APPLICATION

Name: _____ (Age) _____ Gender: M F
Home Address:_____ Home Phone: ( )_____
City, State, Zip: _____ Cell Phone: ( )_____
Email Address: _____ Work Phone: ( )_____
Birth Date:_____/____/____ Social Security #_____ Marital Status: S M D W
Occupation: _____
Spouse's Name: _____ Cell Phone: ( ) _____
How were you referred to this office? _____

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PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:_____
Is this purpose related to an auto accident / work injury? **Yes No If so, when:_____**
When did this condition begin?_____/_____/_____ Did it begin: **Gradual Sudden Progressive over time**
What activities aggravate your symptoms? _____
Is there anything, which has relieved your symptoms?_____
Type of Pain: **Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting**
Does the pain radiate into your: Arm__ Leg__ Does not radiate__ *Is this condition getting worse? **Yes No**
How often do you experience these symptoms throughout the day? **100% 75% 50% 25% Only with activity**
Does complaint(s) interfere with: Work__ Sleep__ Hobbies__ Daily Routine__ Explain:_____
Have you experience this condition before? **Yes No** If so, explain: _____
Who have you seen for this? _____ What did they do?_____
How did you respond?_____

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EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? **Yes No** Who? _____ When?_____
Reason for visits: _____
How did you respond?_____
Did your previous chiropractor take before and after x-rays? **Yes No**
Are you aware of any of your poor posture habits? **Yes No**
Explain:_____

CURRENT HEALTH LIFESTYLE

Do you exercise? Yes No How often?_____
Do you smoke: Yes No How much? _____
Do you drink alcohol? Yes No How much / week? _____
Do you drink coffee? Yes No How many cups a day?_____
Do you take supplements (vitamins, minerals, herbs)? _____

CERVICAL SPINE (NECK)

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body.
Do you experience…

- ☐ Neck Pain
- ☐ Pain in your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands
- ☐ Thyroid conditions
- ☐ Sinusitis
- ☐ Allergies/Hay Fever
- ☐ Recurrent colds/Flu
- ☐ Low Energy/Fatigue
- ☐ TMJ/Jaw Pain/Clicking

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body.
Do you experience…

- ☐ Heart Palpitations
- ☐ Heart Murmurs
- ☐ Tachycardia
- ☐ Heart Attacks/Angina
- ☐ Recurrent Lung Infections/Bronchitis
- ☐ Asthma/Wheezing
- ☐ Shortness of Breath
- ☐ Pain on Deep inspiration/Expiration

THOPRACIC SPINE (MID BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves in your ribs/chest and upper digestive tract, and affect these parts of your body.
Do you experience…

- ☐ Mid Back Pain
- ☐ Pain in your Ribs/Chest
- ☐ Indigestion/Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Tired/Irritable after eating or when you haven't eaten in a while

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) will weaken the nerves in your legs/feet and pelvic organs and affect these parts of your body.
Do you experience…

- ☐ Pain in your hips/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Constipations / Diarrhea
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Low back pain
- ☐ Frequent/difficulty urinating
- ☐ Menstrual irregularities/cramping (female)
- ☐ Sexual dysfunction

Please list any health conditions not mentioned: _____

List any medications currently taking: _____

_____

List all past surgeries: _____

List all previous accidents and falls: _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the bodys ability to express its maximum health potential.

CONSENT TO CARE

I do hereby authorize the doctors of North Houston Spine & Sports Medicine to administer such care that is necessary for my particular case. This care may include consultations, examinations, spinal adjustments and other chiropractic/rehab procedures, including various physical therapy & diagnostic x-rays or any other procedures that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor to allow the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, including those working at this clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic and/or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. The doctor will not be held responsible for any health conditions or diagnoses which are preexisting, giving by another health care practitioner.

I clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at the time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the doctors recommended procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature _____ **Date** _____ *(If under age 18, Parents signature)*

PATIENT CONSENT TO X-RAY

I_____ authorize the performance of diagnostic x-rays examination of myself which the above doctor or his associate may consider necessary of advisable in the course of my examination and treatment.

Signed_____ Date_____

CONSENT TO X-RAY A MINOR CHILD

I_____ authorize the performance of diagnostic x-ray examination of my child or ward which the above doctor or his associate may consider necessary or advisable in the course of examination and treatment.

Signed_____ Date_____

VERFICATION OF NOT PREGNANT

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor or his associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Signed_____ Date _____

PRIVACY CONFIDENTIALITY STATEMENT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

DISCLOSURE OF INFORMATION

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment or healthcare operations. Additional disclosure may be necessary to comply with Workers' Compensation and Public Health Laws as well as judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

Appointment reminder

It is our policy to call your home or office to remind you of your appointment time. If you are not at home we leave a message on your answering machine or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us the number you would prefer.

Facility set up

While our examination and treatment rooms are private, this office utilizes an open exercise/rehabilitation setting. Staff and doctors will maintain to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time.

Your Rights

Send us a written request to see or obtain a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals. Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law. Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting. You have the right to inspect and have a copy of your health information. There is no cost for the first copy. Any copy thereafter will be $20 first 50 pages then .50 cent per page after.

You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement, you will be provided with information about our denial of your amendment and how you may appeal the denial of amendment.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office can be directed to Dr. Tim Runnels by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Ave. S.W.
Room 509F HHH Building
Washington, D.C. 20201

Patient Signature _____ Date _____

The following names are of people who can have access to my protected health information:

Name: _____

Name: _____

Patient Acknowledgement Form
Self-Pay Agreement

Under North Houston Spine & Sports Medicine guidelines, you are financially responsible for any and all payments due at time of service before any services are rendered. You are also financially responsible for all non-covered items such as supplies, vitamins or durable medical equipment.

****By signing this agreement you are stating that you do NOT have any medical insurance that North Houston Spine & Sports Medicine is to submit claims to, nor are you to personally submit any services rendered with any type of medical insurance, automobile claim, Workers Compensation or personal injury case from the signed date below. North Houston Spine & Sports Medicine is not held liable to submit any detail receipts for self-pay services.**

Your acknowledgment below indicates that you understand and have been advised of this information that you agree to pay for the listed medical services or products.

I _____ acknowledge that I have told my medical provider and the front office staff of North Houston Spine & Sports Medicine at the start of my treatment, that any medical service/therapy and/or supplies will not be covered by any insurance or submitted to any insurance. I agree to pay for any and all medical services provided by the doctor.

Signature _____ Date _____