



Chiropractic Case History & Patient Information

Date _____ Patient # _____ Doctor _____

Name _____ Social Security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Fax # _____ Cell Cell _____

Age _____ Birth Date _____ Race _____ Marital Status: M S W D No. of Children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of Nearest Relative _____ Address _____ Phone _____

How were you referred to our office? _____

Family Medical Doctor _____

Purpose of this appointment: _____

Date symptoms appeared or accident happened? _____

Have you ever has the same or a similar condition? Yes No If yes, when and describe: _____

Days lost from work _____

Date of last physical examination _____ What surgeries have you had? (include dates) _____

Serious illnesses (include dates) _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medication or drugs are you taking? _____

Please check any and all insurance coverage that may be applicable in this case.

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16 percent.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____
 Has it been worse recently? Yes No Same Better Slowly Worse
 If yes, when and how? _____
4. How frequent? Constant Daily Varies Night Only
 How long does it last? All Day Few Hours Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom? Yes No
 If yes, describe: _____
6. Describe the pain: Sharp Dull Numbness Tingling
 Aching Burning Stabbing Other
7. Is there anything you can do to relieve the problem? Yes No If yes, describe: _____

 If no, what have you tried to do that has not helped? _____

8. What worsened the problem? Standing Sitting Lying Bending Lifting
 Twisting Other
9. Have you had any broken bones? Yes No If yes, please list and give dates: _____

10. List any major accidents you have had other than those that might be mentioned above: _____

11. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form
 either in the past or the present? Yes No If yes, explain: _____

12. WOMEN ONLY: Are you pregnant or is there a possibility you may be pregnant?
 Yes No Uncertain
13. Remarks: _____

Please place an "X" on the line below to indicate level of problem.

No Symptoms

Extreme Symptoms

Doctor's Signature _____ Date _____

Last Tetanus Shot: _____

REVIEW OF SYMPTOMS

Weight _____ Weight One Year Ago _____ Maximum Weight _____ When _____

Y = A condition you have now

P = A condition you have had in the past

N = Never had

Fatigue	Y	P	N	Emphysema	Y	P	N
Weakness	Y	P	N	Difficulty Breathing	Y	P	N
Arthrodesis	Y	P	N	Shortness of Breathe	Y	P	N
Injections	Y	P	N	Debridement	Y	P	N
Walking Aids	Y	P	N	Heart Disease	Y	P	N
Tens (at home)	Y	P	N	Angina	Y	P	N
Surgery	Y	P	N	High Blood Pressure	Y	P	N
Color Change	Y	P	N	Fasciotomy	Y	P	N
Lumps	Y	P	N	Arthroscopy	Y	P	N
Night Sweats	Y	P	N	Edema	Y	P	N
Headaches	Y	P	N	Arthroplasty (prosthetic placement)	Y	P	N
Head Injury	Y	P	N	Catheter	Y	P	N
Impaired Vision	Y	P	N	Removal of Interbal Fixation	Y	P	N
Corrected Vision	Y	P	N	Nausea	Y	P	N
Traction	Y	P	N	Vomiting	Y	P	N
Hospitalization	Y	P	N	Constipation	Y	P	N
Tearing/Dryness	Y	P	N	Loss of Enjoyment	Y	P	N
Double Vision	Y	P	N	Meniscectomy Arthroscope	Y	P	N
Pallectomy	Y	P	N	Blood in Stool	Y	P	N
Cataracts	Y	P	N	Gas/Bloating	Y	P	N
Confined to Bed	Y	P	N	Other Significant Treatments	Y	P	N
Impaired Hearing	Y	P	N	Liver Disease	Y	P	N
Ear Ringing	Y	P	N	Suturing	Y	P	N
Earaches	Y	P	N	Hemorrhoids	Y	P	N
Dizziness	Y	P	N	Abdominal Pain	Y	P	N
Frequent Colds	Y	P	N	Home Traction	Y	P	N
Sinusitis	Y	P	N	Peptic Ulcer	Y	P	N
Postnasal Drip	Y	P	N	Gall Bladder Disease	Y	P	N
Nose Bleeds	Y	P	N	Pain in Urination	Y	P	N
Sore Mouth/Gums	Y	P	N	Frequent Urination	Y	P	N
Prescribed Medicine	Y	P	N	Delay or Gaps in Treatment	Y	P	N
Cavities	Y	P	N	Reduction	Y	P	N
Change in Taste	Y	P	N	Ligament or Tendon Repair	Y	P	N
Goiter	Y	P	N	(Not Arthroscopy or Arthrotomy)			
Neck Pain	Y	P	N	Kidney Stones	Y	P	N
Cough	Y	P	N	Blood in Urine	Y	P	N
Sputum	Y	P	N	Joint Pain/Stiffness	Y	P	N
Spit Up Blood	Y	P	N	Arthritis	Y	P	N
Immobilization	Y	P	N	Broken Bones	Y	P	N
Asthma	Y	P	N	Muscle Spasms	Y	P	N
Bronchitis	Y	P	N	Deep Leg Pain	Y	P	N
Pneumonia	Y	P	N	Bone Graft	Y	P	N
Duties Under Duress	Y	P	N	Oxygen	Y	P	N

Patient Symptoms

Thrombophlebitis	Y	P	N
Aspiration of Hematoma	Y	P	N
Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle Weakness	Y	P	N
Numbness/Tingling	Y	P	N
Coordination Difficulties	Y	P	N
Release of Adhesions	Y	P	N
Depressions	Y	P	N
Anxiety	Y	P	N
Mood Swings	Y	P	N
Memory Loss	Y	P	N
Drug/Alcohol Abuse	Y	P	N
Difficulty Sleeping	Y	P	N
Phobia	Y	P	N
Thyroid Problem	Y	P	N
Arthrotomy, Meniscectomy, Cruciate	Y	P	N
Excessive Thirst	Y	P	N
Excessive Hunger	Y	P	N
Blood Sugar Dysregulation	Y	P	N
Anemia	Y	P	N
Easy Bleeding	Y	P	N
Blood Transfusion	Y	P	N

FEMALES

Age Menses Began	_____		
Age Menses Ended	_____		
Average Cycle Length	_____		
Average Bleeding Length	_____		
Spotting	Y	P	N
Irregular Cycles	Y	P	N
Nursing/Convalescent Home	Y	P	N
Painful Menses	Y	P	N
Birth Control	Y	P	N
Sexual Difficulties	Y	P	N
STD	Y	P	N
Breast Lumps	Y	P	N
Breast Pain	Y	P	N
Nipple Discharge	Y	P	N
PMS Symptoms	Y	P	N
Menopausal Symptoms	Y	P	N
Vaginal Dryness	Y	P	N

Vaginal Discharge/Sores	Y	P	N
Number of Pregnancies	_____		
Number of Live Births	_____		
Number of Miscarriages	_____		
Number of Abortions	_____		

MALES

Hernias	Y	P	N
Testicular Masses	Y	P	N
Testicular Pain	Y	P	N
Sexual Difficulties	Y	P	N
STD	Y	P	N
Penile Discharge	Y	P	N
Prostate Disease	Y	P	N

Are there any other additional health concerns or questions you have? _____

Please describe a poor experience with a health practitioner you have had in the past.

Please describe a good experience with a health practitioner you have had in the past.

Patient Symptoms

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins and needles, burning, stiffness, aching or stabbing pain.

Numbness: □

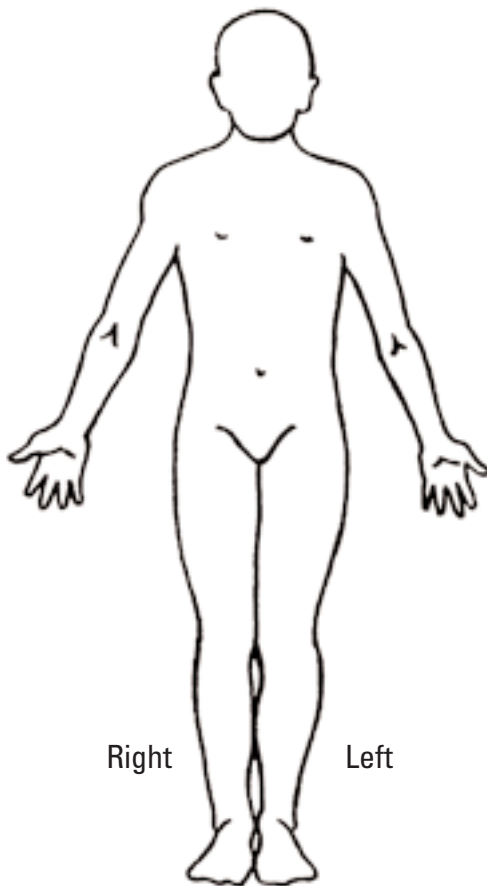
Pins & Needles: .-

Aching Pain: ±

Stabbing Pain: ↑

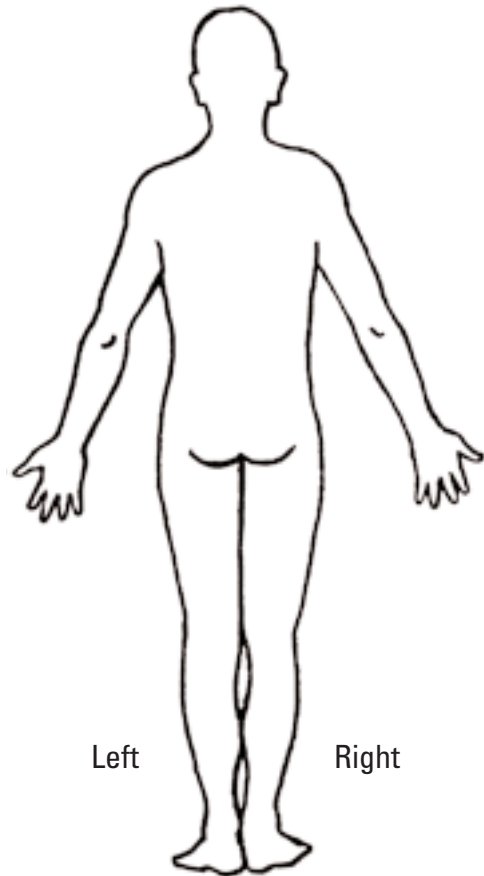
Burning: #

Stiffness: U



Right

Left



Left

Right

Please rate your discomfort on a scale of 1-10.

(1 = mild pain, 10 = the worst pain you've ever felt)

Location

Pain Rating

1. _____
2. _____
3. _____

TO: PATIENTS OF THE HOUSTON SPINE AND REHABILITATION CENTERS

The Houston Spine and Rehabilitation Centers specialize in the treatment of the spine and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, as with any chiropractic and/or physical medicine services there are risks associated with the services we provide.

As your healthcare provider, we feel that it is crucial that you understand these risks. By informing you of these risks we are striving to more actively involve you in our case as well as further assist you in making well-informed decisions regarding your treatment options.

PASSIVE MODALITIES

Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound, electrical stimulation, massage, traction, paraffin, whirlpool and iontophoresis.

The primary risk associated with the passive modalities is skin irritation due to exposure to heat, cold or agents used in the application of modalities, i.e. lotions, pads, paraffin and/or iontophoresis (lidocaine/hydrocortisone). If you have experienced skin sensitivity to heat, cold temperatures and/or lotions or similar products in the past or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release.

Therapeutic interventions are generally quite safe though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise there is also the risk of injury. Though this risk is minimal as you are under the direct supervision of experienced clinical staff, it may still exist.

Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION

Spinal manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax, and may even release the irritation from the nervous system, which may result in other health benefits.

As with any healthcare service there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

DISK HERNIATION

The occurrence of disk herniation during spinal manipulation is highly unlikely. In fact, average disks withstand an average of 23 degrees of rotation and degenerated disks an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 2-3 degrees, this joint would have to fracture to allow any further rotation to occur.

CAUDA EQUINA SYNDROME

It is estimated that the rate of occurrence of the cauda equine syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It is probably higher in patients with a herniated nucleus pulposus, and lower in patients without this anatomic abnormality.

VERTEBROBASILAR ARTERY COMPROMISE

Serious complication of cervical spine manipulation are also rare (none having been reported in any of the clinical trials), but appear to be more common and severe than complication of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebrobasilar artery, leading to stroke or death. The risk is higher for manipulation involving rotation plus extension of the cervical spine than for other types of manipulation, and those persons who have suffered manipulation-related vertebrobasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebrobasilar artery compromise related to cervical spine manipulation is that it occurs one in 1 million manipulations (Hurwitz, 1996; McGregor, 1995).

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT

As your doctor it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examinations and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

I have reviewed the information provided regarding the benefits and risks of treatment provided at The Houston Spine and Rehabilitation Centers. I have been given the opportunity to discuss my questions and/or concerns and by signing below I acknowledge that I understand and accept the risks associated with my treatment.

Patient Signature _____ Date _____

Guardian's Signature _____ Date _____