Patient Contact Information

Victory Chiropractic | 330 Genesis Blvd Suite B, Webster, TX | Tel: (281) 724-1620

Title:	**First:**	**Middle:**	**Last:**	**Nickname:**
Date of Birth:	**Sex:** Male / Female	**Do you have children?** ○ Yes ○ No	**Ages:** _____	
Address:		**City:**	**State:**	**Zip Code:**
Primary/Cell Phone Number:		**Email:**		
Employment (circle one): Employed	Part-Time Student	Full-Time Student	Retired	Other
Occupation:		**Employer:**		
Marital Status (circle one): Single	Married	**Other:** _____	**Spouse's Name:**	
Referred By:		**How May We Contact You? (circle all that apply):** Phone	Email	
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.
Please include your Primary Care and/or Referring Physician if necessary.

Name	Relation	Phone

Consent to Treatment (Minor)

I hereby request and authorize Victory 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.

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

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

_____ _____ _____

Signature **Date** **Relationship**

Patient Medical History

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Name of your Family Doctor/Primary Care Physician?

What City and State?

Date of Last Visit: / /

Date of Last Exam: / /

Past Surgeries (year):

The Reason For This Visit:

Have you been treated by a Medical Physician for this condition? ○Yes ○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/Condition(s): (circle all that apply)

AIDS	Cancer	Emotional Difficulties	Low Blood Pressure	Spinal Disc Disease	
Allergies	Cirrhosis/Hepatitis	Hay Fever	Mental Illness	Rheumatic Fever	Tuberculosis
Anemia	Diabetes	Heart Problem	Mulitple Sclerosis	Scoliosis	Ulcer
Arthritis	Dislocated Joints	High Blood Pressure	Pacemaker	Sinus Trouble	
Asthma	Diverticulitis	HIV/ARC	Polio	STD	
Bone Fracture	Epilepsy	Kidney Trouble	Prostate Trouble	Thyroid Trouble	

Others:

Current Medications:

Family History of Illness: (circle all that apply)

AIDS	Cancer	Emotional Difficulties	Low Blood Pressure	Spinal Disc Disease	
Allergies	Cirrhosis/Hepatitis	Hay Fever	Mental Illness	Rheumatic Fever	Tuberculosis
Anemia	Diabetes	Heart Problems	Multiple Sclerosis	Scoliosis	Ulcer
Arthritis	Dislocated Joints	High Blood Pressure	Pacemaker	Sinus Trouble	
Asthma	Diverticulitis	HIV/ARC	Pollo	STD	
Bone Fracture	Epilepsy	Kidney Trouble	Prostate Trouble	Thyroid Trouble	

Type of Cancer:

Patient Medical History, continued

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Social History:

Alcohol Consumption? ○ Yes ○ No

Coffee Consumption? ○ Yes ○ No

Soda Consumption? ○ Yes ○ No

Water Consumption: _____ ounces/day

Sleep Amount? _____ hours/night

Recreational Drug Use? ○ Yes ○ No

Healthy Eating Rank? (0-poor, 10 excellent)

Exercise Frequency: _____ hours/day

Major Stressors:

Things to Improve:

Other Health Goals:

Smoking History:

Currently Smoke? ○ Yes ○ No

Years Smoked? _____ years

Packs Per Day? _____

Comments on Smoking:

Comments:

Patient Name (Printed): _____

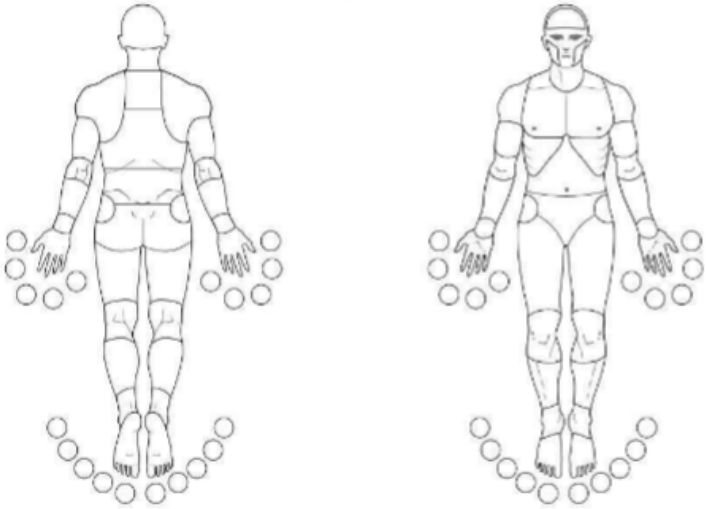
Patient Signature: _____ **Date:** _____

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

VICTORY CHIROPRACTIC

Current Complaints

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below.



Pain / Symptom Intensity:	**0 (None) 1 2 3 4 5 6 7 8 9 10 (Excruciating)**
Mechanism of Injury:	
When and How Did the Condition Occur?	
Frequency (How often?)	**Infrequent < 25% Occasional 25%-50% Frequent 50% - 75% Constant > 75%**
Duration (of pain)?	_____ days, weeks, months, years over the past _____ days, weeks, months, year(s)

When does the pain tend to be at it worst?

Morning Throughout the day End of Day Night During/After strenuous activities

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

Yes No *Where?*_____

The symptoms are described as (circle all that apply):

Dull	**Sharp**	**Throbbing**	**Burning**	**Deep**	**Aching**
Tingling	**Stabbing**	**Cramping**	**Numbness**	**Radiating**	

What makes it worse? (circle all that apply):

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

What makes it better? (circle all that apply):

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

Comments:

Patient's Signature _____

VICTORY
CHIROPRACTIC

Acknowledgement Form

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Victory Chiropractic "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Victory Chiropractic's Notice of Privacy Practices prior to signing this document. Victory 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, payments of my bills, or in the performance of health care operations of Victory Chiropractic. The Notice of Privacy Practices for Victory Chiropractic is also provided upon request at the front desk of this practice and on Victory Chiropractic's website, www.victory-chiro.com. This Notice of Privacy also describes my rights and Victory Chiropractic's duties with respect to my protected health information.

Victory 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 Victory Chiropractic's website, calling the office, requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Consent to Treatment

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/decompression therapy, cupping, dry needling, pneumatic compression, manual muscle therapy, Graston technique, kinesio-tape, 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 Victory 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, bruises, and temporary worsening of symptoms. More serious complications such as fractures and strokes are extremely rare. Your treating doctor, upon request, can explain additional information on side-effects and complications.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for 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 and this may include any staff members or interns of Victory Chiropractic.

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

Patient/Guardian Name (printed):_____

Signature:_____

Date:_____

Staff Member Signature:_____ **Date:**_____

New Patient Appointments: If you cannot keep your appointment, you must cancel or reschedule at least one business day before the appointment time or you will be charged a $25 cancellation/rescheduling fee. This is a non-negotiable fee that cannot be appealed and will not be covered by your insurance provider. In addition, the fee will need to be paid in full before another new patient evaluation can be scheduled.

Card on File: At the time of your first visit you must present a credit or debit to keep on file. Your card will only be charged for missed appointments or appointments canceled or rescheduled after the 24 hour mark.

Insurance & Third Party (i.e. major medical, auto insurance claims, attorney): You may still be responsible for covering any costs related to the services provided that insurance does not cover or has gone to a deductible. This includes examination fees, assessments, treatments, and any other charges incurred. In the event that you are responsible for these charges, you will be sent an invoice with the total amount corresponding to the services rendered and will be given 30 days to fulfill the payment. If the balance is left unpaid after 30 days we will charge the card on file. Should you have any questions regarding this please ask and we would be happy to assist you.

Secondary and Follow-up Appointments: If you cannot keep your appointment, you must cancel it at least one business day before the appointment time or you will be charged a $25 cancellation/rescheduling fee. This is a non-negotiable fee that cannot be appealed, nor billed to your insurance provider.

- If you call the day of and need your appointment rescheduled and can still come in the same day but at a different time, you will <u>not</u> be charged the $25 fee.
- Patients who arrive more than fifteen minutes late for their appointment will be rescheduled to the next available appointment.
- All payments are expected at the time of service. If you are not prepared to pay for your visit, your appointment will be rescheduled to a future date.

I have read and agree to the above conditions

Print Name: _____

Signature: _____

Date: _____