Welcome to ChiroSport Specialists of Dallas. We would like to thank you for coming to our office and taking the first step to achieving a pain-free and healthy lifestyle. Please fill out the questionnaire to the best of your knowledge so that we can address any issues you may have. This will provide the doctor the necessary information needed to design the optimal treatment plan so that you may achieve pain relief and improved quality of life.

PATIENT INFORMATION

Patient Full Name ______________________

Prefer to be called ______________________

Date of Birth ______________ **Sex** **M or F**

Patient SSN ______________________

Marital Status SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Address ______________________

City/State/Zip ______________________

Home Phone ______________ **Work Phone** ______________

Cell Phone ______________ **Email** ______________

Preferred Appointment Reminder: TEXT EMAIL CELL

Work Status EMPLOYED UNEMPLOYED STUDENT RETIRED OTHER

Employer ______________________

Employer Address ______________________

Employer Phone ______________________

Occupation ______________________

How long? (yrs, mths) ______________________

Emergency Contact/# ______________________

Referred By ______________________

GUARANTOR INFORMATION

for patients under 18 years of age

Responsible Party Name ______________________

Date of Birth ______________________

Relationship to Patient ______________________

Resp. Party Address ______________________

Resp. Party Phone ______________________

INSURANCE INFORMATION

**** Please present drivers license & insurance card to Receptionist***

Subscriber Name ______________________

Subscriber Date of Birth ______________________

Subscriber SSN ______________________

Insurance Carrier ______________________

Insurance Claims Address ______________________

City/State/Zip ______________________

Subscriber Employer ______________________

Employer Group Number ______________________

Employer Address ______________________

Employer Phone ______________________

Medical Information

CHIEF COMPLAINT: ____
____

Date injury occurred? __________ How did the injury occur? ____
____

Have you seen a doctor for your current injury? ______ Doctor: _________________ Phone: _________________

Since the injury are you: IMPROVING WORSE ABOUT THE SAME COMES AND GOES

Which activities aggravate/worsen your condition?

_____ standing _____ sitting _____ walking _____ lying down _______________ other

Have you seen a doctor for a previous injury? (Not the injury you are presenting with today.) __________________
____

What was the date of this previous injury? ____

Have you ever had any surgeries? _____ If yes, what type? ____
____

List any medications/herbs/supplements or vitamins you are currently taking and the symptoms you are treating.

Medication/Herb/Supplement: ______________________________ Symptom: ___________________________

Medication/Herb/Supplement: ______________________________ Symptom: ___________________________

Medication/Herb/Supplement: ______________________________ Symptom: ___________________________

Doctor: ____ Phone: _____________________________

Are you feeling or experiencing any of the following: (check all that apply)

_____Tired _____Fatigued _____Stressed _____Lethargic _____No Energy _____Unhealthy

_____ Depressed _____ Indigestion _____ Constipation _____ Insomnia _____ Irritable

Have you ever been diagnosed with any of these conditions?

_____ Diabetes _____ High Blood Pressure _____ Heart Disease _____ Tuberculosis

_____ Cancer _____ AIDS/HIV _____ Anemia _____ Hepatitis A, B or C

_____ Arthritis _____ Asthma _____ Migraines _____ Infection

_____ Ulcers _____ Venereal Disease _____ Epilepsy _____ Influenza

_____ Alcoholism _____ Fibromyalgia _____ ADD/ADHD _____ Chronic Fatigue

Other health issues or concerns:
____

Do you smoke? _____ Frequency: _____ / day _____ packs/week

Do you drink alcohol? _____ Frequency: _____ / day

Do you drink coffee/caffeinated drinks? _____ Frequency: _____ / day

How often do you exercise? _____ NONE _____ DAILY _____ WEEKLY _____ MONTHLY

What type of exercise do you do? ____

Nutrition:

How often do you eat fruits? ____

How often do you eat vegetables? ____

How often do you eat fast food? ____

Do you drink water on a regular basis? _____ If yes, how much per day? __________________________________

The above information is true, complete and accurate to the best of my knowledge.

Signature: ____ Date: ________________

ChiroSport Specialists of Dallas

Please **CIRCLE** all areas of the body to describe your pain as it relates to your injury.

HEAD	AREA	INTENSITY
HEADACHE	ENTIRE HEAD	CONSTANT
FEELS HEAVY	BACK OF HEAD	INTERMITTENT
DIZZINESS	FOREHEAD	OCCASIONAL
FAINTING	TEMPLES	DULL
LIGHT-HEADEDNESS	MIGRAINE	
MEMORY LOSS	TENSION	
LOSS OF BALANCE	SINUS	
EYE		
EAR		
LOSS OF SMELL		
SINUS TROUBLE		
LOSS OF TASTE		
MENTAL DULLNESS JAW PAIN		
JAW PAIN		

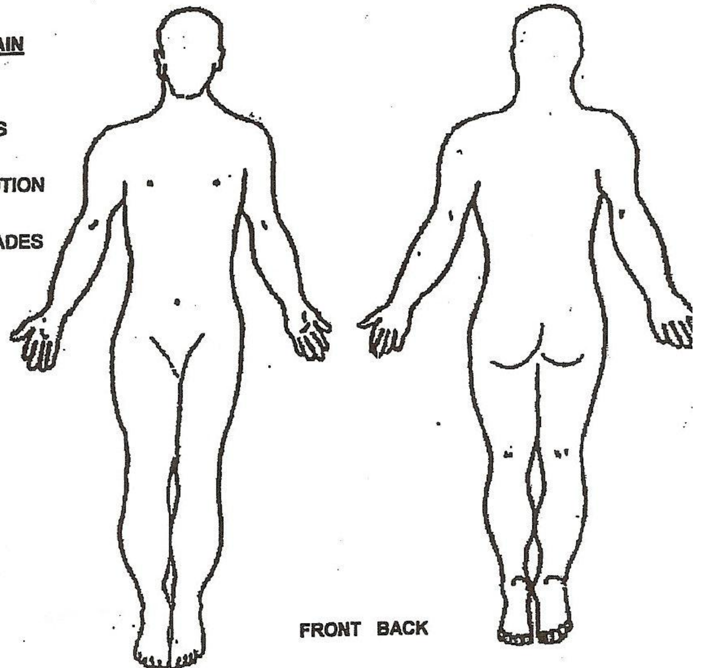
NECK	AREA
PAIN	RIGHT
STIFFNESS	LEFT
RESTRICTED MOTION	BOTH
MUSCLE SPASMS	

SHOULDER	AREA
PAIN	RIGHT
STIFFNESS	LEFT
RESTRICTED MOTION	BOTH

CHEST
CHEST PAIN
RIGHT RIBS IN PAIN
LEFT RIBS IN PAIN
BOTH SIDES OF RIBS IN PAIN
SHORTNESS OF BREATH
PALPITATION

ARMS/HANDS	AREA
PAIN	UPPER FOREARM, WRIST, HAND/FINGERS
PINS & NEEDLES	RIGHT, LEFT, BOTH ARMS, RIGHT, LEFT ALL FINGERS
SWOLLEN JOINTS	RIGHT, LEFT, ALL FINGERS
SORE JOINTS	RIGHT, LEFT, ALL FINGERS
LOSS OF GRIP STRENGTH	RIGHT, LEFT ALL HANDS
COLD HAND	RIGHT, LEFT ALL HANDS
RESTRICTED MOTION	RIGHT, LEFT, BOTH HANDS; RIGHT, LEFT, ALL FINGERS
NUMBNESS	RIGHT, LEFT, BOTH ARMS; RIGHT, LEFT, BOTH HANDS; RIGHT, LEFT, ALL FINGERS

ABDOMEN	MIDBACK PAIN	LOWER BACK PAIN
NAUSEA/VOMITING	PAIN	PAIN
NERVOUS STOMACH	STIFFNESS	STIFFNESS
CONSTIPATION	MUSCLE SPASMS	MUSCLE SPASMS
DIARRHEA	STABBING PAIN	STABBING PAIN
GAS	RESTRICTED MOTION	RESTRICTED MOTION
HIATAL HERNIA	PAIN BETWEEN SHOULDER BLADES	PAIN BETWEEN SHOULDER BLADES



PAIN DRAWING

Please fill this out carefully. Mark the area on you body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation of pain and include all affected areas.

NUMBNESS	= = = = =	BURNING PAIN	X X X X
ACHING PAIN	((((((	PINS AND NEEDLES	O O O
STABBING PAIN	/////		

On a scale of 1 to 10 with 1 being no pain and 10 being intolerable pain, circle the number that would indicate you pain level.

1 2 3 4 5 6 7 8 9 10

PATIENT NAME: ______ DATE: ______

GLUTES/HIPS	PAIN	R-GLUTE	L-GLUTE	R/L GLUTE	
		R-HIP	L-HIP	R/L-HIP	
	NUMBNESS	R-GLUTE	L-GLUTE	R/L GLUTE	
		R-HIP	L-HIP	R/L-HIP	
LEG	PAIN	RIGHT	LEFT	R/L	
	PINS & NEEDLES	RIGHT	LEFT	R/L	
	NUMBNESS	RIGHT	LEFT	R/L	
	GROIN PAIN	RIGHT	LEFT	R/L	
	RESTRICTED MOTION	RIGHT	LEFT	R/L	
KNEE	PAIN	RIGHT	LEFT	R/L	
	STIFFNESS	RIGHT	LEFT	R/L	
	SWELLING	RIGHT	LEFT	R/L	
	NUMBNESS	RIGHT	LEFT	R/L	
ANKLE	PAIN	RIGHT	LEFT	R/L	
	STIFFNESS	RIGHT	LEFT	R/L	
	NUMBNESS	RIGHT	LEFT	R/L	
FOOT	PAIN	RIGHT	LEFT	R/L	FEET
		RIGHT	LEFT	R/L	TOES
	PINS & NEEDLES	RIGHT	LEFT	R/L	FEET
		RIGHT	LEFT	R/L	TOES
	NUMBNESS	RIGHT	LEFT	R/L	FEET
		RIGHT	LEFT	R/L	TOES
	CRAMPS	RIGHT	LEFT	R/L	
	SWELLING	RIGHT	LEFT	R/L	
	COLD SENSATION	RIGHT	LEFT	R/L	

MOVEMENT	SITTING	RISING FROM SEATED	WORKING
Difficulty in:	STANDING	RISING FROM LYING	LIGHT LIFTING
	STOOPING	WALKING	MODERATE LIFTING
	BENDING	RIDING	HEAVY LIFTING
		REPEATED LIFTING	
GENERAL	NERVOUSNESS	ANXIETY	TENSION
	STRESS	COLD SENSATION	TREMORS
	IRRITABLE	RUN DOWN FEELING	EXCESSIVE PERSPIRATION
	DEPRESSION	DIFFICULTY SLEEPING	UNEXPLAINED WEIGHT GAIN
	FATIGUE	UNEXPLAINED WEIGHT LOSS	
SEXUAL	MENSTRUAL PAIN	HEAVY MENSTRUATION	PRE-MENSTRUAL SYNDROME
	CRAMPING WITH MENSTRUAL PAIN	IMPOTENCY	DECREASED SEX DRIVE

CONSENT TO CHIROPRACTIC CARE

CHIROSPORT SPECIALISTS OF DALLAS strives to ensure the highest quality care to our patients. All fields of health care are associated with potential risks. In order to provide you health care services, it is our lawful obligation to ensure you fully understand the potential benefits and risks associated with chiropractic and physical therapy. This is called **INFORMED CONSENT OF TREATMENT**.

CHIROSPORT SPECIALISTS OF DALLAS utilize the highest trained personnel and facilities to assist the doctor with portions of your examination, x-ray procedure, massage, exercise, physical therapy, etc. Below is a brief summary to ensure you are familiar with procedures, benefits and risks.

History

Chiropractic is a field of health care that involves the "movement" of bones by "hand" in order to stimulate a neurological response within the body. The origin of chiropractic dates back to 1895 when D.D. Palmer restored a man's hearing just by adjusting the neck. Thomas Edison once stated, "The doctor of the future will give no medicine, but will interest his patients in care of the human frame, in diet and in the cause and prevention of disease."

Research Studies

According to a New England Journal of Medicine, one of the top sources of health research, studies have found that chiropractors are experts in the treatment of low back pain. Research exists demonstrating chiropractic efficiency and cost effectiveness. The AHCPR expert panel concluded that spinal manipulation is recommended and effective form of initial treatment for acute low back pain. The RAND Corporation determined that spinal manipulation is appropriate for the treatment of acute low back pain and that 94% of all manipulations are performed by chiropractors. In 1995 a study by the Ontario Ministry of Health found chiropractic as long-term effectiveness in treatment of low back pain, finding that improvement in all patients at 3 years revealed 29% increase in those treated by chiropractic versus hospitals. In 1996 a study in the American Journal of Managed Care concluded that chiropractic is extremely promising method of treatment for acute back and neck discomfort and recommended its wider application in managed health care. Evidence is surfacing every day supporting chiropractic care.

Adjustment/Manipulation

The chiropractic adjustment or manipulation involves the movement of a joint, or the space between two bones. This may be performed on any joint in the body. The doctor utilizes his hands in order to perform the adjustment' therefore the doctor's hands may contact the patient's back, hips, tailbone, ribs, neck, ankle or other "bony" area. Upon set up of the adjustment, the chiropractor will place one hand on the desired joint to be adjusted and the other hand in a stabilizing position such as your shoulder or forearms. Due to "bones" being covered by soft tissue, this soft tissue may be contacted in order to perform an adjustment. The patient must realize that the doctor is focused on the joint below. IT IS VERY IMPORTANT THAT YOU UNDERSTAND THIS DISTINCTION IN ORER TO PREVENT ANY MISCONSTRUED EVENT. Upon the adjustment, the doctor will perform a quick controlled thrust into the joint. A "popping sound" will result and is due to the release of nitrogen gas in the fluid surrounding the joint as it moves. When adjusting the neck region, the sound is amplified due to location of the ear. The adjustment is usually not painful.

Potential Risks

Stroke or Cardio-Vascular Accident is the most serious risk associated with cervical / neck adjustments. Stroke means that a portion of brain does not receive enough oxygen from the blood stream. Chiropractic adjustments have been associated with the verbal artery only because it is located within the neck vertebral bones. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. 92% of reactions as a result of vertebral artery compromise occur within 24 hours and 63% occur immediately. The most recent studies (Journal of CCA, Vol. 37, No. 2, June, 1993) estimate that the incident of this type of stroke is 1 per 3 million upper cervical adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would be statistically associated.

CONSENT TO CHIROPRACTIC CARE (CONTINUED)

Disc Herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Yet occasionally chiropractic treatment will aggravate the problem and rarely will surgery become necessary for corrections. Rarely chiropractic adjustments may also cause a disc problem only if the disc is in a weakened state.

Soft Tissue Injury primarily refers to the muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely will a chiropractic treatment damage a muscle or ligament. The result is a temporary increase in pain and necessary treatments to resolve the irritation, but there are no long term affects to the patient.

Rib Fracture may occur in the thoracic spine or middle back. Your ribs are attached to the spine and extend from your back to your chest area. Fractures rarely occur and are usually associated with patients whom have weakened bone structure, such as osteoporosis.

Burns are a result of electrical / non-electrical equipment that generate heat, produce sound waves, or remove heat from the body. These include electrical muscle stimulations; hot/ice packs and ultrasound. Each person's skin sensitivity is different to these modalities. The result is increased pain, on or below the skin, which may or may not develop a blister.

Soreness is common for chiropractic adjustments, traction, physical exercise, and massage in the area of treatment. This is nearly always a temporary symptom that decreases as your body undergoes therapeutic change. It is not dangerous, but please notify your doctor so he can modify your treatment if required.

Other Alternatives for Care

Over the counter and prescription medications can decrease the symptoms but may produce undesirable adverse reactions such as nausea, headaches, dizziness, back pain, bleeding and other effects. A 1998 study in the Journal of American Medical Association revealed overall incidence of serious adverse drug reactions to be 6.7% and fatal reactions in 0.32%. **Premature return to work or household chores** may aggravate the condition, extend the recovery time and increase the chance of future injury. **Complete bed rest is not recommended** due to approximately 1.5% muscle mass loss per day as well as cardio-pulmonary (heart-lung) deconditioning at 15% within 10 days. **Hospitalization / Surgery** bears the risk of exposure to communicable disease, adverse reaction to anesthesia iatrogenic (doctor induced) mishap and death.

Confidence and trust in your personal health provider is of utmost importance. As chiropractic doctors we have attained 7 or more years of college and internship, completed advanced diplomat programs and have treated everyone from an infant to a senior citizen. As Primary Treating Doctors, we have the ability to manage your injury and refer you for the necessary testing and evaluations you may require. Chiropractic has proven to be the safest, most effective and fastest growing alternative therapy.

DO NOT SIGN BELOW UNTIL YOU HAVE READ AND COMPLETELY UNDERSTAND THE ABOVE INFORMATION. If you have any questions, please ask your doctor.

By signing below, I state that I have read or have had read to me the explanation of chiropractic, physical therapy, and related treatment. I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or said minors interest) to undergo the treatment recommended. Having been informed I hereby give my consent to CHIROSPORT SPECIALISTS OF DALLAS, P.A., staff and doctors to perform treatment. I also acknowledge that no guarantee or assurance as to the treatment results associated with any symptom, disease, or condition as a result of the treatment received at this clinic may be obtained.

Patient/Minor's Name:____Relationship: ___________________________

Patient/Guardian Signature:____Date: __________________________________

Doctor's Signature:____Date: __________________________________

CONSENT TO ACTIVE RELEASE THERAPY CARE

Your ART doctor specializes in the care of soft tissue injuries utilizing Active Release Techniques. The first thing he will do is determine if your problem is indeed muscular in nature. There is a 95% chance that this will be the case. Should you be in the 5% that needs to see another professional, the ART provider will inform you as soon as possible. Some conditions may require 2 to 3 weeks to determine if ART will be effective for your condition, depending how chronic your condition is. If ART is not effective in improving your condition or if the ART provider feels ART is inappropriate for your conditions, the ART provider will inform you and will redirect your care.

The vast majority of patients who see the ART provider have symptoms caused by scar tissue, which has formed on muscles, ligaments and nerves, and is interfering with daily activities. These events can unfold over a period of days or even years.

- The symptoms that caused you to feel discomfort are likely part of a cycle of physical stress and muscular dysfunction. To restore full, free, and painless motion to your muscles, your ART doctor will use a proven, specific, step-by-step recovery process:
- Identify muscles involved
- Use ART to break up scar tissue between muscles
- Teach you specific stretches to perform frequently throughout the day to help the recovery process and prevent reoccurrence.

On average, up to 6 sessions are necessary to see improvement of most soft tissue injuries. Success is faster when problems are reported early. Some individuals with certain medical conditions or lifestyles will take longer than others to improve. Your ART sessions may be uncomfortable. Every individual's tissue tolerance is different. It is your responsibility to communicate with the ART doctor during and after care to give him feedback so that he can make modifications if necessary. In the unlikely event that your skin bruises after a session, communicate this to the ART provider so that he knows to apply less force in future treatments. He will also inform you if icing the area will help.

It is your responsibility to participate in you care by doing the stretches that you will be taught. It is also your responsibility to tell your provider whether or not you feel like the care is helping you.

This form is not intended to be a waiver or release of any claims the employee may have at law.

A medical history will be asked of you by the ART provider to insure that ART is appropriate for your condition. This information will be kept private between you and the ART professional.

I understand the type of treatment. I understand that the ART Program is an elective course of care. I can withdraw from ART care at any time by notifying the doctor. I give my consent, and choose to receive ART:

____

Patient Name (print) Patient Signature

My muscular discomfort level in the area I need cared for (when at its worst) - Circle One:

1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

AUTHORIZATION FOR RELEASE OF CONDITION INFORMATION TO WELLNESS PROFESSIONALS

At times it may be beneficial to collaborate with other health professionals of your wellness team. Whether it's your masseuse, personal trainer or other wellness specialist, it is important to your treatment plan for everyone involved to be made aware of the most current information regarding you condition, so that the proper modifications and/or suggestions can be made so that everyone involve has an accurate depiction of your current situation.

With your interest in mind, please allow ChiroSport Specialists the permission to disclose limited information regarding your care and physical limitations with other members of your wellness team.

I, ____________________________________, will allow for information regarding my condition to be shared with the following wellness professionals:

Name | Title/Specialty | Facility Affiliation | Phone

Name | Title/Specialty | Facility Affiliation | Phone

This authorization includes but is not limited to release of information relating to all records, diagnosis, treatment of any and all injuries, and any and all other information pertaining to my past or present medical condition or treatment.

I understand that my records are confidential and cannot be disclosed without my written permission except when permitted or required by law.

I understand I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization.

This authorization will expire 365 days from the date of my signature unless I revoke this authorization prior to that time

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Patient Name (printed) | Signature | Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY PRACTICES

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Policies of ChiroSport Specialists of Dallas, which describes the practice's policies and procedures regarding the use of any of my Protected Health Information created, received or maintained by the practice.

Printed Name	Signature	Date

CANCELLATION AND "NO SHOW" POLICY

Due to the desirability of appointment times with ChiroSport Specialists, our office policy maintains that our patients MUST PROVIDE A TWENTY-FOUR HOUR CANCELLATION NOTICE for all services. Failure to contact the office at least 24 hours in advance or not showing for appointment will result in a fee of $25.00, which must be paid prior to any future appointments.

I understand and agree to the terms of the cancellation policy.

Printed Name	Signature	Date

PAYMENT POLICY

Co-insurance amounts are to be collected at the time services are received. We accept cash, checks, VISA/Mastercard, American Express and Discover. All medical services provided are directly charged to the patient or responsible party. If our physicians are contracted with your insurance carrier we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. We will extend a 90-day period for your carrier to process claims and issue any payments due. If after 90 days your carrier fails to issue expected payment, all charges due will become member responsibility and billed accordingly.

I understand and agree to the terms of the payment policy.

Printed Name	Signature	Date

Please retain my credit/debit card billing information on my account for all patient charges.

Card Type/Number	Expiration Date	Cardholder Signature