ChiroSport Specialists of Dallas
PATIENT INTAKE FORM

For Office Use Only

Date: _____ Time: _____

Acct#:_____ Acct Type:_____

Height: _____Weight: _____

BP: _____ /_____ Pulse: _____

O2: _____ Temp: _____

Name: _____ Preferred to be called: _____
Date of Birth: _____ / _____ / _____ Sex: M F Marital Status: S M D

Address: _____
City: _____ State: _____ Zip: _____
Phone (Cell): _____ (Home):_____

Email:_____ Reminders: Text / Email
Referred by: _____
Work Status: Employed Unemployed Student Retired Employer_____ Occupation_____

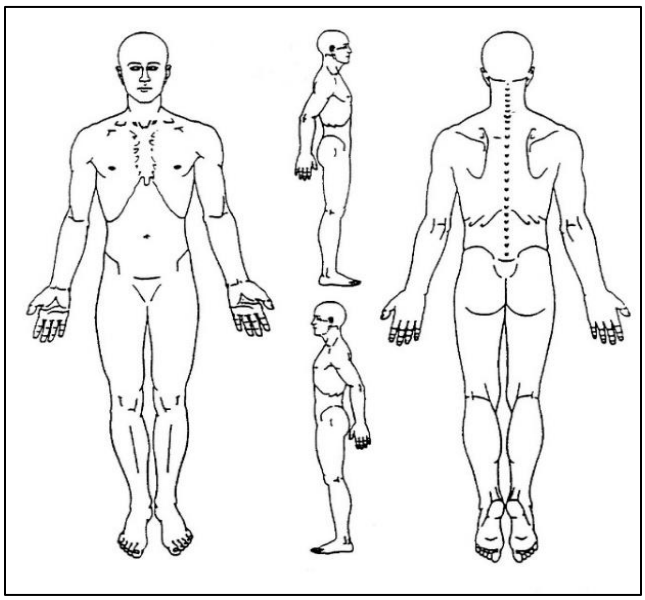
Do you have Insurance? YES NO If so, select **one**: ____Blue Cross Blue Shield ____Aetna ____Humana
Member Identification #: _____ Group #: _____
Subscriber Name: _____ Subscriber Date of Birth: _____Relation to Subscriber:_____

Are you covered under Medicare YES NO *(we are not Medicare providers, please see the front desk for further details)*

Primary reasons for seeking chiropractic care

Primary Condition: _____
_____
Condition 2: _____
_____
Have you ever received Chiropractic Care? YES NO If yes, when and by whom? _____
Are the above condition(s) are due to Auto Accident: YES NO -or- Work-Related Injury: YES NO
Date of injury: _____Has the accident been reported? _____ if so, to whom? _____

Condition(s) began when and how? (Briefly describe the accident, injury or illness and state the date of onset):
_____
_____
_____
_____
Does anything aggravate the condition(s)? YES NO If Yes, what _____
Does anything make the condition(s) better? YES NO If Yes, what _____



Mark the area on the body figures below where you feel the described sensation or pain. Mark the areas where pain radiates or spreads with arrows (→,←,↖,↗,↓,↑) to indicate the direction of the radiating pain and include *all* affected areas.

Please circle the Quality of the complaints/pain:

Aching	Burning	Dull	Pulling
Sharp	Shooting	Stabbing	Stinging
Throbbing	Absent		

Grade Intensity/Severity:

(No complaint) **0 1 2 3 4 5 6 7 8 9 10** (Very severe pain)

Frequency of symptoms:

Occasional Intermittent Frequent Constant Absent

ChiroSport Specialists of Dallas

PAST HEALTH HISTORY

Do you have or have had any of the following diseases?

_Appendicitis	_ADD/ADHD	_Diabetes	_Influenza	_Pleurisy
_Anemia	_Asthma	_Epilepsy	_Ulcers	_Measles
_Arthritis	_Covid-19	_Goiter	_Heart.Disease	_Whooping.Cough
_Alcoholism	_Chronic Fatigue	_Fibromyalgia	_Migraines	_Rheumatic Fever
_Aids/HIV	_Cancer	_HepatitisA,B,C	_Tuberculosis	
	_Chickenpox	_Mumps	_Mental.Disorder	

Do you suffer from any condition other than that which you are now consulting us? __YES __NO if so, which _____

Previous conditions/illnesses you have had in your life:_____

Previous injury or trauma: _____

Previous treatments or care you have sought for your condition(s): _____

Tests/Studies:

Date: Reason for taking:

_____ _____

Imaging:

Date: Reason for taking:

_____ _____

Injections:

Date: Reason for taking:

_____ _____

Surgeries:

Date: Type of Surgery:

_____ _____

_____ _____

Medications:

Medication Reason for taking

_____ _____

_____ _____

_____ _____

Allergies:

_____

Social History:

How often do you exercise?	Daily	Weekly	Sometimes	Never
How often do you drink alcohol?	Daily	Weekly	Sometimes	Never
How often do you smoke?	Daily	Weekly	Sometimes	Never
Do you use recreational drugs?	Yes	No		
How is your diet?	Healthy	Sometimes Healthy	Fast Food	

Family Health History:

Associated Health Problems or deaths in immediate family or relatives:

Mother: Cancer Heart Diabetes Other_____

Father: Cancer Heart Diabetes Other_____

Sibling: Cancer Heart Diabetes Other_____

Relative: Cancer Heart Diabetes Other/relation:_____

FEMALES ONLY:

Are you Pregnant Now? YES NO

Pregnancies/Date of Delivery/Outcome:

_____

_____

What was the date of the beginning of your last menstrual period? _____

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REVIEW OF SYSTEMS

CONSTITUTIONAL
□ *DENY ALL*
□ Chills
□ Drowsiness
□ Fainting
□ Fatigue
□ Fever
□ Night Sweats
□ Weakness
□ Weight Gain
□ Weight Loss

INTEGUMENTARY
□ *DENY ALL*
□ Breast Lumps/Pain
□ Change in Nail Texture
□ Change in Skin Color
□ Eczema
□ Hair Growth
□ Hair Loss
□ History of Skin Disorders
□ Hives
□ Itching
□ Paresthesia
□ Rash
□ Skin Lesions

PSYCHIATRIC
□ *DENY ALL*
□ Agitation
□ Anxiety
□ Appetite Changes
□ Behavioral Changes
□ Bipolar Disorder
□ Confusion
□ Depression
□ Homicidal Indication
□ Insomnia
□ Location disorientation
□ Memory Loss
□ Substance Abuse
□ Suicidal Indication
□ Time Disorientation

EYES
□ *DENY ALL*
□ Blindness
□ Blurred Vision
□ Cataracts
□ Change in Vision
□ Dry Eyes
□ Eye Pain
□ Field Cuts
□ Glaucoma
□ Sensitivity to Light
□ Tearing
□ Wears Glasses

ENMT
□ *DENY ALL*
□ Bad Breath
□ Dentures
□ Deviated Septum
□ Difficulty Swallowing
□ Discharge
□ Dry Mouth
□ Ear Drainage
□ Ear Pain
□ Frequent Sore Throats
□ Head Injury
□ Hearing Loss
□ Hoarseness
□ Loss of Smell
□ Loss of Taste
□ Nasal Congestion
□ Nose Bleeds
□ Post Nasal Drip
□ Sinus Infections
□ Runny Nose
□ Snoring
□ Ringing in Ears
□ TMJ Problems
□ Ulcers

CARDIOVASCULAR
□ *DENY ALL*
□ Angina
□ Chest Pain
□ Claudication
□ Heart Murmur
□ Heart Problems
□ High Blood Pressure
□ Low Blood Pressure
□ Orthopnea
□ Palpitations
□ Shortness of Breath
□ Swelling of Legs
□ Varicose Veins

GASTROINTESTINAL
□ *DENY ALL*
□ Abdominal Pain
□ Belching
□ Black, Tarry Stool
□ Constipation
□ Diarrhea
□ Heartburn
□ Hemorrhoids
□ Indigestion
□ Jaundice
□ Nausea
□ Rectal Bleeding
□ Abnormal Stool Caliber
□ Abnormal Stool Consistency
□ Vomiting
□ Vomiting Blood

ENDOCINE
□ *DENY ALL*
□ Color Intolerance
□ Diabetes
□ Excessive Appetite
□ Excessive Hunger
□ Excessive Thirst
□ Goiter
□ Hair Loss
□ Heat Intolerance
□ Unusual Hair Growth
□ Voice Changes

RESPIRATORY
□ *DENY ALL*
□ Asthma
□ Bronchitis
□ Dry Cough
□ Productive Cough
□ Coughing Up Blood
□ Difficulty Breathing
□ Difficulty Sleeping
□ Hemoptysis
□ Pneumonia
□ Sputum Production
□ Wheezing

GENITOURINARY
□ *DENY ALL*
□ Birth Control Therapy
□ Burning Urination
□ Cramps
□ Erectile Dysfunction
□ Frequent Urination
□ Hesitancy/Dribbling
□ Hormone Therapy
□ Irregular Menstruation
□ Lack of Bladder control
□ Prostate Problems
□ Urine Retention
□ Vaginal Bleeding
□ Vaginal Discharge

HEMATOLOGIC/ LYMPHATIC
□ *DENY ALL*
□ Anemia
□ Bleeding
□ Blood Clotting
□ Blood Transfusion
□ Bruise easily
□ Lymph Node Swelling

MUSCULOSKELETAL
□ *DENY ALL*
□ Arthritis
□ Neck Pain
□ Decreased Motion
□ Gout
□ Injuries
□ Joint Pain
□ Joint Stiffness
□ Locking Joints
□ Back Pain
□ Muscle Cramps
□ Muscle Pain
□ Muscle Twitching
□ Muscle Weakness
□ Swelling

NEUROLOGICAL
□ *DENY ALL*
□ Change In concentration
□ Change in Memory
□ Dizziness
□ Headache
□ Imbalance
□ Loss of Consciousness
□ Loss of Memory
□ Numbness
□ Seizures
□ Sleep Disturbance
□ Slurred Speech
□ Stress
□ Strokes
□ Tremors

ALLERGIC/ IMMUNOLOGIC
□ *DENY ALL*
□ History of Anaphylaxis
□ Itchy Eyes
□ Sneezing
□ Specific Food Intolerance

ChiroSport Specialists of Dallas

CONSENT TO CHIROPRACTIC/ A.R.T. CARE

ChiroSport Specialists of Dallas strives to ensure the highest quality care to our patients. All fields of healthcare are associated with potential risks. In order to provide you health care services, it is our lawful obligation to ensure you an Informed Consent of Treatment, where you fully understand the potential benefits and risks associated with chiropractic, physical therapy and A.R.T.

The chiropractic adjustment or manipulation involves the movement of a joint, or the space between the two bones. This may be performed on any joint in the body. Our doctors utilize their hands in order to perform the adjustment therefore the doctors' hands may contact the patient's back, hips, knees, ribs, neck, ankle, or other "bony" areas. The patient must understand that the soft tissues that cover the bones/joints may be contacted in order to perform an adjustment and it is VERY IMPORTANT that you understand the distinction in order to prevent any misconstrued event. A "popping" sound is a normal occurrence that can be heard or felt when the adjustment is performed; know that it is the quick controlled thrust into the joint that results in a release of Nitrogen gas within the fluid of a joint capsule as it moves. The adjustment is usually not painful.

Our doctors specialize in Active Release Techniques (A.R.T.) which focuses on care of soft tissue injuries. Some conditions may require 2 to 3 weeks to determine if ART will be effective for your condition. If A.R.T. is not effective in improving your condition our providers will inform you and redirect your care. Most patients that seek A.R.T. have symptoms caused by scar tissue, which has formed on muscles, ligaments and nerves causing pain, lack of motion, and difficulty with daily activities. These symptoms can unfold over a period of days or even years. A.R.T. is used to break up the scar tissue between the muscles identified to be causing the issues and in conjunction with chiropractic care you are introduced to specific stretches to perform through the day to help the recovery process and prevent reoccurrence. Your A.R.T. sessions may be uncomfortable; everyone's tissue tolerance is different, and it is your responsibility to communicate with the doctor during and after care to give feedback so that modifications can be made if necessary. It is unlikely that bruising will occur after a session, however, if this occurs speak to your doctor and they can apply less force in future treatments.

Our facility uses the newest tools in treatment, recovery and alternative care. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound may be used for treatment. Other tools such as instrument assisted soft tissue mobilization (I.A.S.T.M.), cupping, compression therapy and laser therapy are a few of the additional treatments the doctors may include to your treatment/care plan. Soreness in the area of treatment is common following chiropractic adjustments, A.R.T., traction, cupping, I.A.S.T.M, physical exercise and massage. Confidence and trust in your personal health provider is of utmost importance, as primary treating doctors we can manage your injury and refer you for the necessary testing and evaluations required. It is your responsibility to participate in your care by doing the stretches and at-home care plan you will be taught, as well as communicating with your doctor whether you feel the care is helping you.

Possible risks and complications, as with any health care procedure, are possible following a chiropractic manipulation. Complications can include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to the intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications like a blister may occur again in rare occurrence but tell your doctor if this occurs. The risks of complications due to chiropractic treatment have been described as "rare". Rib Fractures in the thoracic spine rarely occur and are usually associated with patients with weakened bone structure like osteoporosis. Disc Herniations, although frequently successfully treated by chiropractors, can occasionally aggravate the problems and rarely will surgery become necessary. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million about as often as complications are seen from the taking of a single aspirin tablet and can be even further reduced by screening procedures. 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.

DO NOT SIGN BELOW UNTIL YOU HAVE READ AND COMPLETLEY UNDERSTAND THE ABOVE INFORMATION, if you have any questions or concerns please ask your doctor.

By signing below, I state that I have read or had read to me the explanation of the Chiropractic, physical therapy, A.R.T. and alternative methods related to treatment. I understand the type of treatment, I understand that the ART program is an elective course of care that I can withdraw from at any time by notifying the doctor. 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 staff and doctors to perform treatment. I also acknowledge that no guarantee or assurance to the treatment results associated with any symptoms, disease or condition as a result of the treatment received at this clinic may be obtained. I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize ChiroSport Specialists of Dallas to provide me with chiropractic care, in accordance with this state's statutes.

Patient Name_____ Patient/Guardian Signature_____ Date_____

Doctor Name_____ Doctor Signature_____ Date_____

CONSENT OF INTERNSHIP STUDIES, PHOTO & VIDEO RELEASE

I acknowledge that ChiroSport Specialists of Dallas is a teaching facility that at times has interns who shadow and assist the doctors and staff, if I am not comfortable with another person in my treatment room, I will let the doctor know. I also acknowledge that our doctors, staff or any of their assignees may take photographs and videos of my treatment/care at their facility. I understand the photographs and videos will be used as a record of my care and may be used for communication with other health care professionals, publications, social media, and advertising. I further understand that if the photographs or videos are used my identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs or videos. If I wish to revoke this consent, I may do so in writing. ***If declining this consent, leave blank.***
I understand and agree to allow for internship studies, and the use of my photos and videos as stated above.

Printed Name Patient/Guardian Signature Date

PRIVACY POLICIES

I acknowledge that the ChiroSport Specialists of Dallas privacy policies are available upon request and that my protected health information will be protected by HIPAA guidelines, these notices describe how your protected health information may be used and disclosed and how you can get access to this information.

Printed Name Patient/Guardian Signature Date

CANCELLATION AND "NO SHOW" POLICY

Due to the desirability of appointment times with ChiroSport Specialists of Dallas Doctors, 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 up for an appointment will result in a fee of **$50.00**, which must be paid prior to any future appointments or will be billed at the end of that business day per our "Auto Bill" program policy.

Printed Name Patient/Guardian Signature Date

INSURANCE AND PAYMENT POLICY

Payment is 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. We are not always contracted with every plan each carrier offers; we are contracted with most BCBS PPO, BCBS HMO, AETNA, HUMANA plans. However, you will be responsible for a balance deemed patient responsibility/non-covered by your insurance and billed accordingly. If you have not met your deductible, we will file to your insurance and any remaining balance will be billed to you after we receive the explanation of benefits statement from your insurance carrier. 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 Patient/Guardian Signature Date

AUTO-BILL POLICY

Credit/Debit Card billing information may be stored and used for all patient charges incurred. This information is encrypted and stored in each individual account and may not be transferred between accounts. Same cards may be used amongst multiple accounts however, each must be entered/saved separately. Co-insurance amounts, payment for services, supplies or therapies as well as balances and charges for Late Cancellations or No-Shows will be deemed acceptable charges made at the end of the business/service day. I understand that my payment information will be stored securely and understand and acknowledge the use of my Auto Bill payment for charges and balances incurred. To utilize the Auto-Bill Program see the front desk for details.

Printed Name Patient/Guardian Signature Date