FAMILY & SPORTS CHIROPRACTIC

FRISCO, TX

Name:_____ Gender:_____ DOB: ____/____/____ Age:_____

Address:_____

Phone:_____ Email:_____

Occupation:_____ Marital Status: S M D W

How did you hear about us? _____

Would you like to use your Health Insurance? Y / N Insurance Company:_____

History of Present and Past Complaints

What brings you in today? 1.)_____

2.)_____

Do you know what may have caused this?_____

When did your symptoms begin?_____

Since your symptoms began, have they become: Better – Worse – Stayed the same

Have you ever had the same or similar condition? Y / N If so, when? ____/____/____

How would you describe your pain/discomfort? Dull / Sharp / Burning / Tingling / Numb / Throbbing

No Pain 0 - - 1 - - 2 - - 3 - - 4 - - 5 - - 6 - - 7 - - 8 - - 9 - - 10 Worst Pain

How often? 0%-25% of the time / 26%-50% of the time / 51%-75% of the time / 76%-100% of the time

What have you tried in the past to solve your complaint?_____

What makes it better?_____

What activities make it worse?_____

What lifestyle activities have you given up or changed due to this problem? (Ex: exercise, sleep, mood, work)

_____

Have you been to a Chiropractor before? Y / N

If Y, was it for a similar complaint? Y / N When? Month_____ Year_____

Past / Family / Social History

Do you currently have, or have had in the past, any of the following?

Rheumatoid Arthritis (Spine)	Y	N
Ankylosing Spondylitis	Y	N
Fracture(s)	Y	N
Dislocation(s)	Y	N
Unstable Os Odontoideum	Y	N
Vertebral Column Malignancy	Y	N
Bone or Joint Infection(s)	Y	N
Myelopathy	Y	N
Cauda Equina Syndrome	Y	N
Vertebrobasilar Insufficiency	Y	N
Major Artery Aneurysm	Y	N

Articular Hypermobility Disease	Y	N
Severe Demineralization of Bone	Y	N
Benign Bone Tumor (Spine)	Y	N
Bleeding Disorder	Y	N
Currently taking anticoagulants	Y	N
Progressive Radiculopathy	Y	N
Numbness/Weakness	Y	N

Previous Major Illnesses/Injuries:_____

Operations / Hospitalizations / Surgeries:_____

History of any of the following: Heart Attack / Stroke / Transient Ischemic Attack

Current Medications:_____

Allergies:_____

Do you have any congenital or hereditary conditions? Y / N _____

Are there any *immediate* family members that suffer from:

Stroke / Heart Attack / Cancer / Diabetes / Degenerative Disk Disease / Osteoarthritis / Osteoporosis

If so, who?_____ Any other “runs in the family” conditions?_____

Social History

How often do you exercise? Never / Monthly / Weekly / Daily / Other_____

Work / School lifestyle includes: Sitting / Standing / Light Labor / Heavy Labor / Desk & Computer

Habits: Tobacco? Never / Sometimes / Often Alcohol? Never / Sometimes / Often

Caffeine? Never / Sometimes / Often 8 hours sleep? Never / Sometimes / Often

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient Signature:_____ Date: ____/____/____

Review of Systems

Please X each item below for each sign or symptoms you presently or previously experience(d):

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control
__ Hormone Replacement
__ Cramps/Backaches
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Breast Pain

If any of the above are marked, please indicate the date of occurrence: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient Name:_____

Patient Signature:_____ Date: ____/____/____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information/Insurance assignment

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.
The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.
I do here by designate Jacob Stutz DC LLC (hereafter referred to as "my doctor", to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan with respect to any medical or other healthcare expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain record, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I received from my doctor.

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Jacob Stutz DC LLC as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/ healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/ insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

INFORMED CONSENT

Dr. Stutz will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process. There are certain complications that can occur as a result of spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, costovertebral strains and separation. Rare complications include but are not limited to: stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. Dr. Stutz is aware of these complications, and in order to minimize their occurrence, will take precautions. These precautions include but are not limited to my taking a detailed clinical history and examining the patient for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, this information should be disclosed during the clinical history. The use of electrical stimulation may also be applied directly to your skin as a therapeutic modality to supplement your care. There are certain complications that can occur as a result of electrical stimulation. These complications include, but are not limited to dermal burns. I realize that, in spite of the possible complications, my contemplated diagnostic procedure and/or treatment is necessary and desired by me. I acknowledge no guarantees have been made to me concerning the results of the procedure, operation or treatment. I specifically and fully consent to the above procedure(s) based upon my analysis of the risks, benefits and alternatives. I realize that it is mandatory that I give as accurate, current and complete medical and personal history as possible, and to follow any and all instructions as directed by Dr. Stutz.

Patient Name:_____

Patient Signature:_____ Date: ____/____/____

Legal Guardian Signature (if applicable) _____