

VERITY CHIROPRACTIC

Patient Intake Please Complete All Fields

Date: _____

Patient # _____

Name: (Mr. Mrs. Ms. Dr.) _____

Address: _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell(_____) _____ Fax(_____) _____

Date of Birth ____/____/____ Age _____ Social Security # _____ - _____ - _____

Marital Status: M S D W Number of Children: _____ Email Address _____

Occupation: _____ Employer _____

Employer's Address: _____ Phone #:(_____) _____

Spouse Name: _____ Social Security # _____ - _____ - _____

Spouse's Date of Birth: _____

Occupation: _____ Employer _____

Employer's Address _____ Phone #:(_____) _____

Emergency Contact: _____ Phone #:(_____) _____

How did you hear about our office? _____

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

Major Medical Medicare Secondary Medicaid Auto Accident Other

Name of Primary Insurance Company _____

Address _____ Phone #:(_____) _____

ID#: _____ Group #: _____

Name of Secondary Insurance Company (if any) _____

Address _____ Phone #:(_____) _____

ID#: _____ Group #: _____

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 payors 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.

Affidavit Signature: _____ Date: _____

Dr. Initials: _____

VERITY CHIROPRACTIC

Name: _____ (Cont'd)

Primary Care Physician Name : _____ Phone:(_____) _____

Date of Last Physical _____

May Rodgers Stein Chiropractic Center contact your Primary Care Physician on your behalf if necessary? _____

Please describe the purpose of this appointment _____

Number of doctors seen for this condition 1 2 3 4 5 6 7 8 9 10

What is your major symptom? _____

What does this prevent you from doing or enjoying? _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___

If yes, when and how? _____

How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___ Other___ please describe _____

How long does it last? All Day ___ Few Hours ___ Minutes _____

Have you had X-rays taken? (Circle) low back_date ___/___/___ neck_date ___/___/___ chest_date ___/___/___

Other _____ Date ___/___/___

Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___

Burning ___ Stabbing ___ Other _____

What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___

Lifting ___ Twisting ___ Other _____

Please rate your pain using the following scale: (0=no pain, 10 = worst possible pain):

Current pain intensity: 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Average pain intensity: 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Worst pain intensity: 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__

Education level

- Grade 8 or less
- Partial high school
- High school graduate
- Some college
- College graduate
- Masters or Higher

Employment Status

- Paid full time
- Paid part time
- Homemaker
- Student
- Unemployed
- Retired
- Other

Main Work Activity

- Heavy labor
- Light labor
- Mostly sitting at desk
- Mostly standing
- Mostly walking/moving about
- Driving or operating vehicle

Job Satisfaction

- Really like my job
- Like my job
- No opinion
- Dislike my job
- Really dislike my job

Do you smoke? _____ If yes, how many packs per day. _____

Do you drink alcohol? _____ If yes, amount _____

Do you drink caffeine? _____ If yes, amount _____

Doctor: _____

Dr. Initials: _____

VERITY CHIROPRACTIC

Name: _____ (Cont'd)

PATIENT HISTORY

PERSONAL HISTORY

Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____ Others _____

Unusual Childhood Diseases: _____

Adult Illnesses or Conditions: _____

Surgeries/Hospitalizations: _____

Fractures: _____

Please list all Medications/ Supplements that you are currently using and the reason(s) you are using them:

Are you allergic to any drugs or medications? _____

Do you have allergies to any of the following? Food _____ Airborne _____ Lotions/oils/perfumes _____ Seasonal _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you?

Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

N = Now

P = Previously

Headaches _____ Frequency _____

Neck Pain _____

Stiff Neck _____

Sleeping Problems _____

Back Pain _____

Nervousness _____

Tension _____

Irritability _____

Chest Pains/Tightness _____

Dizziness _____

Shoulder/Neck/Arm Pain _____

Numbness in Fingers _____

Numbness in Toes _____

High Blood Pressure _____

Difficulty Urinating _____

Weakness in Extremities _____

Breathing Problems _____

Fatigue _____

Lights Bother Eyes _____

Ears Ring _____

Heart Attack/Stroke _____

Sexually transmitted disease _____

Heart valve problems _____

Loss of Balance _____

Fainting _____

Loss of Smell _____

Loss of Taste _____

Unusual Bowel Patterns _____

Feet Cold _____

Hands Cold _____

Arthritis _____

Muscle Spasms _____

Frequent Colds _____

Fever _____

Sinus Problems _____

Diabetes _____

Indigestion Problems _____

Joint Pain/Swelling _____

Menstrual Difficulties _____

Weight Loss/Gain _____

Depression _____

Loss of Memory _____

Buzzing in Ears _____

Thyroid problems _____

Heart murmur _____

Dr. Initials: _____

VERITY CHIROPRACTIC

Name: _____ (Cont'd)

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

| CONDITION | FATHER Age [] | MOTHER Age [] | SPOUSE Age [] | BROTHER(S) Age [] Age [] | SISTERS Age [] Age [] | CHILDREN Age [] Age [] |
|---------------------|-------------------|-------------------|-------------------|-------------------------------|----------------------------|-----------------------------|
| Arthritis | | | | | | |
| Asthma-Hay Fever | | | | | | |
| Back Trouble | | | | | | |
| Bursitis | | | | | | |
| Cancer | | | | | | |
| Constipation | | | | | | |
| Diabetes | | | | | | |
| Disc Problem | | | | | | |
| Emphysema | | | | | | |
| Epilepsy | | | | | | |
| Headaches | | | | | | |
| Heart Trouble | | | | | | |
| High Blood Pressure | | | | | | |
| Insomnia | | | | | | |
| Kidney Trouble | | | | | | |
| Liver Trouble | | | | | | |
| Migraine | | | | | | |
| Nervousness | | | | | | |
| Neuritis | | | | | | |
| Neuralgia | | | | | | |
| Pinched Nerve | | | | | | |
| Scoliosis | | | | | | |
| Sinus Trouble | | | | | | |
| Stomach Trouble | | | | | | |
| Stroke | | | | | | |
| Other: | | | | | | |

If any of the above family members are deceased, please list their age at death and cause:

Dr. Initials: _____

VERITY CHIROPRACTIC

Name: _____ (Cont'd)

Please use the following key to accurately mark the areas in which you feel the described sensations. Include all affected areas.

Dull Ache **NNN**

Stabbing/Cutting **/////**

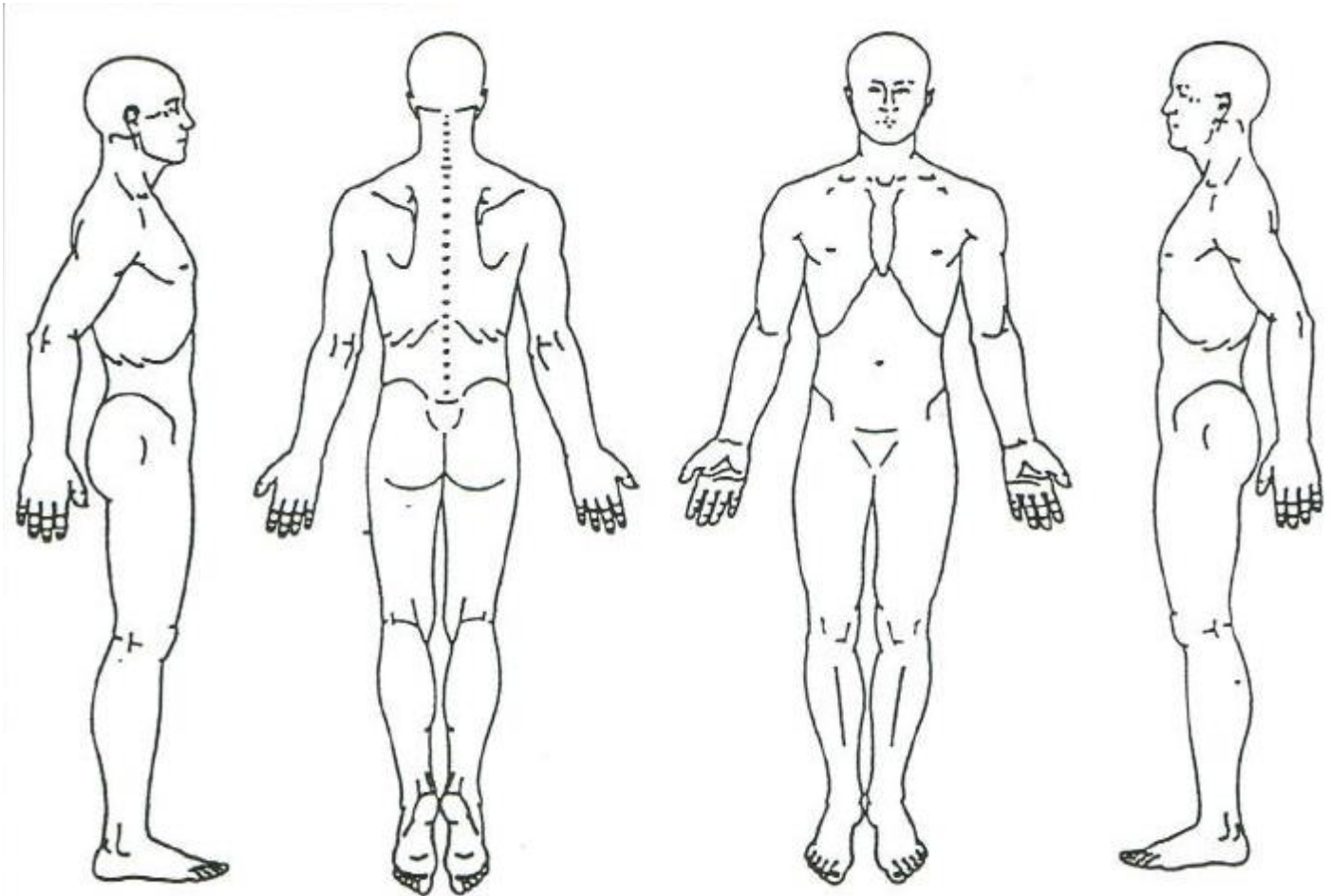
Burning **XXX**

Pinching **PPPP**

Cramping **SSSSS**

Numbness **-- -- -- -- --**

Tingling (pins & needles) **OOOO**



Using the scale 0-100, with 0=no pain and 100= worst possible pain, please write the number indicating your pain level _____.

Affidavit Signature: _____ Date: _____

Dr. Initials: _____

VERITY CHIROPRACTIC

Dr. Initials: _____

Verity Chiropractic
Dr. Kenneth Watson D.C.
1907 Cypress Creek Road, ste 107
Cedar Park, TX, 78613
(512)215-0844

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

Printed name of Patient

X _____
Signature of Patient

Date

X _____
Signature of Representative (if patient is minor or handicapped)

Date

X _____
Witness to Patients' Signature

Date

Dr. Initial: _____

VERITY

CHIROPRACTIC

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

Name _____ DOB: ___/___/___ Date _____

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 undersign 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.

By _____
Patient's Signature

Date _____
(Month/Day/Year)

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent/Guardian (circle one)