

NEW PATIENT INFORMATION

Health by Hand(s)
Wellness Center
2510 Little Road, Arlington, TX
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www.healthbyhandswellness.com

Demographic Information

*Denotes required information

Patient Name

Title: _____
Nick Name: _____
*First Name: _____
Middle Name: _____
*Last Name: _____
Suffix: _____

Address

Address 1: _____
Address 2: _____
City: _____
State: _____
*Zip: _____

Contact Information

Primary phone: _____
Secondary phone: _____
*Mobile phone: _____
*Text Message Appointment Reminder: Yes No

Work email: _____
*Home email: _____
Best Contact Method: _____

Personal Information

*Date of Birth: _____
Social Security #: _____
*Gender: _____
*Marital Status: Single Married Other
*Employment Status: Employed FT Student PT Student Retired Other Self Employed
Race: White Black/African American Hispanic American Indian/Alaska Native
 Asian Indian Chinese Filipino Japanese Korean Vietnamese
 Native Hawaiian/Pacific Islander Guamanian or Chamorro Samoan Other
*Multi-Racial: Yes No
*Ethnicity: Hispanic or Latino Non-Hispanic or Latino
*Preferred language: _____

*Verification Question: In what city were you born? What is the name of your favorite pet?
 What high school did you attend? What street did you grow up on?
 What is your favorite color? What was the make of your first car?
 What is your favorite movie? When is your anniversary?

*Verification Answer (At least 6 characters): _____

Name of primary care physician: _____

Have you ever consulted a chiropractor before? Yes No

If so, who: _____

Last visit: _____

Referred by: _____

Welcome!

Please allow our staff to photocopy your driver license and all available medical documents or insurance cards.

Office Use Only

___ Consent Forms Signed

___ Email address in C.C.

___ Demographics keyed in

Patient Name: _____ DOB: __/__/_____

Employment Information

* Denotes required information

*Occupation: _____

Employer Name: _____

Employer Address: _____

Employer City: _____

Employer State: _____

Employer Zip: _____

Work Phone: _____

May we call your cell phone at work: Yes No

May we call your work phone: Yes No

*Physical Stress level: Low Medium High

*Injured on the job: Yes No

*Job Description: _____

*Activities: _____

Other Health Care Providers

* Denotes required information

*Provider Name: _____

Provider Type: _____

Provider City: _____

Provider State: _____

Provider Phone: _____

*I have seen this provider for my primary problems: Yes No

*Provider Name: _____

Provider Type: _____

Provider City: _____

Provider State: _____

Provider Phone: _____

*I have seen this provider for my primary problems: Yes No

*Provider Name: _____

Provider Type: _____

Provider City: _____

Provider State: _____

Provider Phone: _____

*I have seen this provider for my primary problems: Yes No

Patient Name: _____ DOB: __/__/_____

We want you to know how your Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. A more detailed account of our policies and procedures concerning the privacy of your Patient Health Information are included in the HIPAA notice (“Notices of Privacy Practices”) that is part of the New Patient Package and it is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the Insurance companies require for payment.
2. A patient’s written consent need only be obtained one time for all subsequent care given the patient in this office.
3. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
4. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse to give care.

I have read and understood how my personal information will be used and I agree to these policies and procedure.

Patient’s signature _____ **Date** _____

or

Parent’s or Guardian’s Signature _____ **Date** _____

Patient Name: _____ DOB: __/__/_____

HEALTH PROBLEMS AND CONCERNS: Please Print and List your top health concerns in order of priority

1. _____
2. _____
3. _____
4. _____
5. _____

TREATMENT: What type of treatment are you looking for? _____

I am looking for the most minimal amount of care to “patch up” my problem. I am looking to resolve my symptoms, then go on to “fix the cause” I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

Have you had any intolerance or reactions to treatments? Yes No

Describe: _____

Have you ever been in the emergency room? For what reason and when? _____

Have you ever been on crutches? For what reason and how long? _____

Have you been in an auto accident? Past year Past 5 years Over 5 years Never. If yes, describe:

Surgeries & Trauma What surgeries, trauma, or stitches have you had and when? _____

Have you had elective surgery (tummy tuck, face lift, liposuction, etc.) ? _____

Have you ever had full-body anesthesia (i.e. to remove tonsils, wisdom teeth, etc)? _____

Metal or plastic inside your body (pins, clamps, plates)? _____

Breast implants _____, Prostheses _____, Body piercing _____, Tattoos _____

Women: Last menstrual period: __/__/_____ Are you pregnant? Y N; Taking birth control pills? Y N

Nr of pregnancies ___; Nr of children: ___; Miscarriages/Abortions: ___; Complications: _____

Vaginal bleeding other than period Painful menstrual periods _____

Back pain with menstrual periods Other menstrual problems _____

Pap smear within last two years

Patient Name: _____ DOB: __/__/_____

Problem Areas - Use a Body diagram and a Problem Sheet for each Problem

* Denotes required information

*Describe your problem #1: _____

*On a scale of 0-10 , rate the intensity: _____
Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
(0 = no pain; 1-3 = aware of pain, but can carry on activities of daily routine;
4-7 = intermittent/certain motions produce pain; 8-10 = constant, severe,
nothing makes it better without drugs).

*How did your problem begin: _____

*Onset date of problem: _____

How often do you experience symptoms: _____

What is the nature of your symptoms: _____
(check all that apply) _____
___ Dull ___ Sharp ___ Throbbing ___ Burning ___ Deep
___ Aching ___ Tingling ___ Stabbing ___ Cramping
___ Numbness ___ Radiating

Does it affect other areas of your body: _____
___ Yes ___ No

To what areas does the pain radiate, shoot or travel: _____

*What makes it worse: ___sitting ___standing ___walking ___bending _____
___stooping___ looking up ___looking down ___movement ___climbing stairs ___lying
supine ___lying prone ___reaching ___sneezing ___sleeping ___twisting ___lifting
___exercise ___rest ___driving ___typing ___morning ___afternoon ___evening _____
Comments: _____

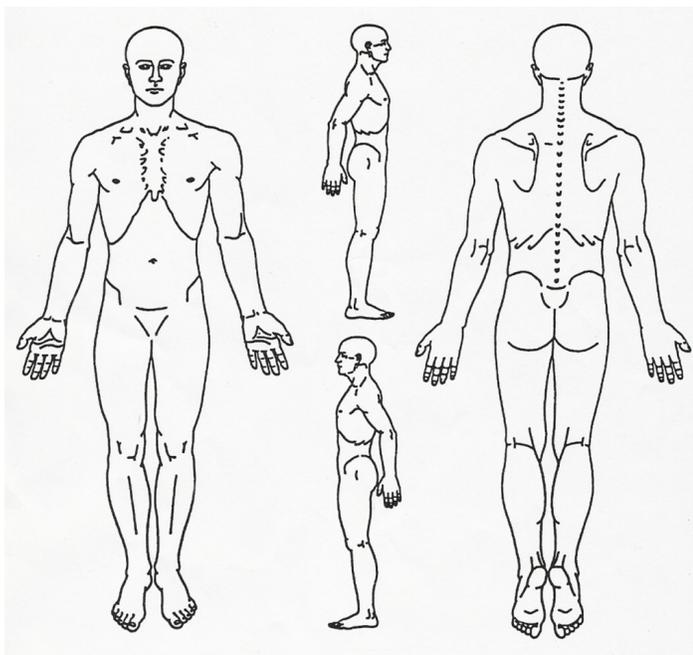
What makes it better: ___sitting ___lying ___knees bent ___no movement
___movement ___support ___sleeping ___exercise ___morning ___afternoon
___evening _____

What have you done to relieve the symptoms: _____
(check all that apply) _____
___ Prescription Medication ___ Over the counter drugs
___ Homeopathic remedies ___ Physical Therapy
___ Surgery ___ Acupuncture ___ Chiropractic
___ Massage ___ Ice ___ Heat ___ Other

*What should we know about your current condition: _____

Location of symptom #1 (use a body diagram and a Problem Sheet for each Problem)

*Please use a red (or different color) pen to especially mark all SCARS, surgeries or trauma on this diagram 1 along with your Problem #1



Patient Name: _____ DOB: __/__/_____

Problem #2 - Use a Body diagram and a Problem Sheet for each Problem

***Describe your problem #2:** _____

***On a scale of 0-10 , rate the intensity:** _____
Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
(0 = no pain; 1-3 = aware of pain, but can carry on activities of daily routine;
4-7 = intermittent/certain motions produce pain; 8-10 = constant, severe,
nothing makes it better without drugs).

***How did your problem begin:** _____

***Onset date of problem:** _____
How often do you experience symptoms: _____

What is the nature of your symptoms: _____
(check all that apply) _____
_____ Dull ___ Sharp ___ Throbbing ___ Burning ___ Deep
_____ Aching ___ Tingling ___ Stabbing ___ Cramping
_____ Numbness ___ Radiating
Does it affect other areas of your body: _____
_____ Yes ___ No

To what areas does the pain radiate, shoot or travel: _____

***What makes it worse:** ___sitting ___standing ___walking ___bending _____
_____stopping looking up ___looking down ___movement ___climbing stairs ___lying
supine ___lying prone ___reaching ___sneezing ___sleeping ___twisting ___lifting
_____exercise ___rest ___driving ___typing ___morning ___afternoon ___evening _____

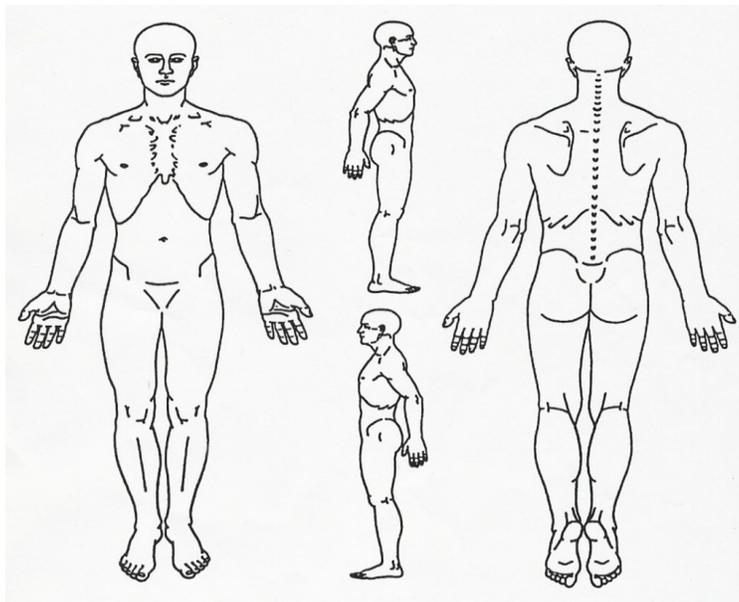
Comments:

What makes it better: ___sitting ___lying ___knees bent ___no movement
_____movement ___support ___sleeping ___exercise ___morning ___afternoon
_____evening _____

What have you done to relieve the symptoms: _____
(check all that apply) _____
_____ Prescription Medication ___ Over the counter drugs
_____ Homeopathic remedies ___ Physical Therapy
_____ Surgery ___ Acupuncture ___ Chiropractic
_____ Massage ___ Ice ___ Heat ___ Other

***What should we know about your current condition:** _____

Location of symptom #2:



Patient Name: _____ DOB: __/__/_____

Problem #3 -

***Describe your problem #3:**

*On a scale of 0-10 , rate the intensity: _____
Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest
(0 = no pain; 1-3 = aware of pain, but can carry on activities of daily routine;
4-7 = intermittent/certain motions produce pain; 8-10 = constant, severe,
nothing makes it better without drugs).

*How did your problem begin: _____

*Onset date of problem: _____

How often do you experience symptoms: _____

What is the nature of your symptoms: _____
(check all that apply) _____

Does it affect other areas of your body: _____

To what areas does the pain radiate, shoot or travel: _____

*What makes it worse: _____

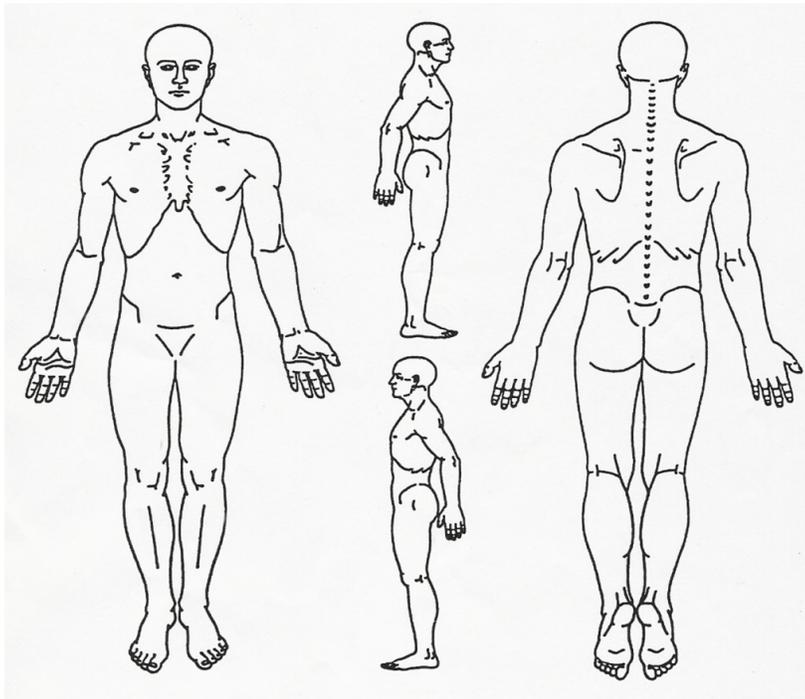
Comments:

What makes it better: _____

What have you done to relieve the symptoms: _____
(check all that apply) _____

*What should we know about your current condition: _____

Location of Symptom #3:



Patient Name: _____ DOB: __/__/_____

Medications

* Denotes required information *** PRINT CLEARLY ***

***Name:** _____

***Dosage:** _____ (ie., mg/mcg) **Quantity:** _____ **Frequency:** _____

***Start Date:** _____

Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

***Name:** _____

***Dosage:** _____ (ie., mg/mcg) **Quantity:** _____ **Frequency:** _____

***Start Date:** _____

Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

***Name:** _____

***Dosage:** _____ (ie., mg/mcg) **Quantity:** _____ **Frequency:** _____

***Start Date:** _____

Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

***Name:** _____

***Dosage:** _____ (ie., mg/mcg) **Quantity:** _____ **Frequency:** _____

***Start Date:** _____

Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

***Name:** _____

***Dosage:** _____ (ie., mg/mcg) **Quantity:** _____ **Frequency:** _____

***Start Date:** _____

Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

***Name:** _____

***Dosage:** _____ (ie., mg/mcg) **Quantity:** _____ **Frequency:** _____

***Start Date:** _____

Obtained: Over the counter By prescription

Prescribed by: _____

Comments: _____

Patient Name: _____ DOB: __/__/_____

Nutritional Supplements

* Denotes required information

*Name: _____
*Start Date: _____
Manufacturer: _____
Quantity: _____
Frequency: _____
Taken with water: Yes No Taken with food: Yes No
Reason for taking: _____
Comments: _____

*Name: _____
*Start Date: _____
Manufacturer: _____
Quantity: _____
Frequency: _____
Taken with water: Yes No Taken with food: Yes No
Reason for taking: _____
Comments: _____

*Name: _____
*Start Date: _____
Manufacturer: _____
Quantity: _____
Frequency: _____
Taken with water: Yes No Taken with food: Yes No
Reason for taking: _____
Comments: _____

*Name: _____
*Start Date: _____
Manufacturer: _____
Quantity: _____
Frequency: _____
Taken with water: Yes No Taken with food: Yes No
Reason for taking: _____
Comments: _____

*Name: _____
*Start Date: _____
Manufacturer: _____
Quantity: _____
Frequency: _____
Taken with water: Yes No Taken with food: Yes No
Reason for taking: _____
Comments: _____

Patient Name: _____ DOB: __/__/_____

Allergies

* Denotes required information *** PRINT CLEARLY ***

***Name:** _____
***Medication** __ Yes __ No
Related
***Reaction:** _____
***Onset Date:** _____
Comments: _____

***Name:** _____
***Medication** __ Yes __ No
Related
***Reaction:** _____
***Onset Date:** _____
Comments: _____

Personal Medical History

Illnesses

Illness: _____
Start date: _____
End date: _____

Surgeries

Surgery: _____
Date: _____
 __ In patient __ Out Patient

Surgery: _____
Date: _____
 __ In patient __ Out Patient

Surgery: _____
Date: _____
 __ In patient __ Out Patient

Surgery: _____
Date: _____
 __ In patient __ Out Patient

Hospitalizations

Reason: _____
Date: _____
Duration: _____

Patient Name: _____ DOB: __/__/_____

Injuries (Include broken bones, blows to head, and loss of consciousness)

Injury: _____
Date: _____

Have you ever been treated by a *chiropractor* before? Yes No. If yes when was the last time __/__/_____

Do you have a preferred chiropractic technique? Yes No. Describe: _____

Age when you first experienced spinal (back, neck) problems: _____ yrs.

Have you had **X-rays MRI/CAT scan** taken of the following: Back Neck Chest Other _____

Last X-ray, MRI, CAT scan, Date or Year __/__/_____ Reason: _____

Family Medical History: Identify any conditions that you, or any of your family members have now or have had in the past: (M = Mother, F = Father, B = Brother, S = Sister, D = Daughter, SN = Son, G = Grandparent, X = Self; Indicate "Date of Onset" for Self) Date/Year of onset is ONLY for "self"

____ Alcoholism

____ Epilepsy

____ Septicemia (bacteremia or blood poisoning)

____ Anemia

____ Eczema

____ Sudden Infant Death Syndrome

____ Autism (psychological disorder)

____ Goiter

____ Tuberculosis

____ Depression ____ ADDH

____ Anxiety

____ HIV/AIDS

____ Ulcer(s)

____ Deep vein thrombosis (clotting disorder)

____ High Blood Pressure

____ Osteoporosis

____ Cancer (specify type of cancer)

____ Hypertension

____ Detached retina

Type: _____

____ Kidney Disease

____ Cold sores

____ Mumps

____ High Cholesterol

____ COPD (Lung Disease)

____ Polio

____ Stroke ____ Brain Attack

____ Asthma ____ Chronic Bronchitis

____ Rheumatic fever

____ Gastrointestinal Disorder (colon polyp, Crohn's disease, irritable bowel syndrome)

____ Emphysema ____ Pneumonia

____ Dementia or Alzheimer's

____ Heart Attack

____ Diabetes (circle which one: Type 1, Type 2, or pre-diabetes)

____ Deep Vein Thrombosis (clotting disorder)

Review of Body Systems

Musculoskeletal	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Osteoporosis:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Scoliosis:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Back Problems:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Knee injuries:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Shoulder Problem:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
TMJ Issues:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Arthritis:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Neck Pain:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Hip Disorders:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Foot/ankle pain:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Elbow/Wrist Pain:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Poor Posture:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Neurological	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Anxiety:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Headaches:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Pins & needles:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Depression:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Dizziness:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Numbness:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Cardiovascular	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
High Blood Pressure:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
High cholesterol:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Angina:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Low Blood Pressure:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Poor circulation:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Excessive bruising:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Respiratory	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Asthma:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Emphysema:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Shortness of breath:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Apnea:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Hay fever:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Pneumonia:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Digestive	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Anorexia/bulimia:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Food sensitivities:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Constipation:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Ulcer:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Heartburn:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Diarrhea:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Sensory	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Blurred vision:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Hearing loss:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Loss of smell:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
ringing in ears:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Chronic ear infection:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Loss of taste:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Integumentary	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Skin cancer:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Eczema:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Hair loss:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Psoriasis:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Acne:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Rash:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Endocrine	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Thyroid issues:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Hypoglycemia:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Swollen glands:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Immune disorders:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Frequent infection:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Low energy:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Genitourinary	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Kidney stones:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Bedwetting:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Erectile dysfunction:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Infertility:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Prostate issues:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
PMS symptoms:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Constitutional	<input type="checkbox"/> No issues	<u>Onset Year</u>	<u>Onset Year</u>
Fainting:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Poor appetite:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Sudden weight gain/loss:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Low libido:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Fatigue:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset
Weakness:	<input type="checkbox"/> Have	<input type="checkbox"/> Had	_____ Onset

Patient Name: _____ DOB: __/__/_____

Smoking History

* Denotes required information

* Have you ever been a smoker: __Yes __No

*Do you currently smoke: __ Yes __ No

Years smoked: _____

Packs a day: _____

Interest in quitting on a scale of 0-10: Lowest - 0 1 2 3 4 5 6 7 8 9 10 - Highest

How long since you stopped: _____

Social History

* Denotes required information

Consumption

How much alcohol do you drink daily: _____

If you drink, what is alcoholic drink choice: _____

How many cups of coffee do you drink daily: _____

What do you put in your coffee: _____

How much soda pop do you drink daily: _____

If you drink soda pop, what type soda: _____

How much water do you drink daily: _____

What kind/source is your water: _____

How much do you depend on pain relievers: _____

Do you use recreational drugs: __ Yes __ No

Stress Information

*How much physical stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

*How much emotional stress are you under: Not much - 0 1 2 3 4 5 6 7 8 9 10 - A lot

What are the major stressors in your life: _____

Sleeping Information

How many hours do you sleep per night: _____

What is your preferred sleeping position: _____

What type of mattress & pillow do you have: _____

How old are your mattress & pillow: _____

Healthy Eating & Exercise Information

What have you eaten/drunk in last 24 hours: _____

How much regular exercise do you perform: _____

*Rate your healthy eating habits: Not healthy - 0 1 2 3 4 5 6 7 8 9 10 - Healthy

Typical eating habits: __ Skip Breakfast __ 2 meals per day __ 3 meals per day

__ Snacking between meals

What would be the most significant thing that would improve your health:

What additional health goals do you have:

Daily Activities

* Denotes required information

Rate the "Current" difficulty and the "Prior" Difficulty of the following daily activities on a scale of 0-10 (0 being easiest, 10 most difficult):

<u>Activity</u>	<u>*Current Difficulty</u>										<u>*Prior Difficulty</u>											
Bending:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Carrying:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Driving:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Housework:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Lying:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Opening jars:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Personal care:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Picking up objects:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Pulling:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Pushing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Reaching:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Reaching behind:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Reading:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Recreation:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Running:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Shopping:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Sit to stand:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Sitting:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Sleeping:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Standing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Throwing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Walking:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
Writing:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10

Comments: _____

Patient Name: _____ DOB: ___/___/_____

To answer YES to the questions below, put a circle around the YES.
 To answer NO to these question, put a circle around the No.
 Please answer all questions. If you are not sure, guess.

Do you sweat or tremble a lot during examinations or questioning?	Yes	No	Was anyone in your family ever a patient in a mental hospital (for their nerves)?	Yes	No
Do you get nervous and shaky when approached by a superior?	Yes	No	Are you extremely shy or sensitive?	Yes	No
Does your work fall to pieces when the boss or a superior is watching you?	Yes	No	Do you come from a shy or sensitive family?	Yes	No
Does your thinking get completely mixed up when you have to do things quickly?	Yes	No	Are your feelings easily hurt?	Yes	No
Must you do things very slowly in order to do them without mistakes?	Yes	No	Does criticism always upset you?	Yes	No
Do you always get directions and orders wrong?	Yes	No	Are you considered a touchy person?	Yes	No
Do strange people or places make you afraid?	Yes	No	Do people usually misunderstand you?	Yes	No
Are you scared to be alone when there are not friends near you?	Yes	No	Do you have to be on your guard even with friends?	Yes	No
Is it always hard for you to make up your mind?	Yes	No	Do you always do things on sudden impulse?	Yes	No
Do you wish you always had someone at your side to advise you?	Yes	No	Are you easily upset or irritated?	Yes	No
Are you considered a clumsy person?	Yes	No	Do you go to pieces if you don't constantly control yourself?	Yes	No
Does it bother you to eat anywhere except in your own home?	Yes	No	Do little annoyances get on your nerves and make you angry?	Yes	No
Do you feel alone and sad at a party?	Yes	No	Does it make you angry to have anyone tell you what to do?	Yes	No
Do you usually feel unhappy and depressed?	Yes	No	Do people often annoy and irritate you?	Yes	No
Do you often cry?	Yes	No	Do you flare up in anger if you can't have what you want right away?	Yes	No
Are you always miserable and blue?	Yes	No	Do you often get into a violent rage?	Yes	No
Does life look entirely hopeless?	Yes	No	Do you often shake or tremble?	Yes	No
Do you often wish you were dead and away from it all?.	Yes	No	Are you constantly keyed up and jittery	Yes	No
Does worrying continually get you down?	Yes	No	Do sudden noises make you jump or shake badly?	Yes	No
Does worrying run in your family?	Yes	No	Do you tremble or feel weak whenever someone shouts at you?	Yes	No
Does every little thing get on your nerves and wear you out?	Yes	No	Do you become scared at sudden movements or noises at night?	Yes	No
Are you considered a nervous person?	Yes	No	Are you often awakened out of your sleep by frightening dreams?	Yes	No
Does nervousness run In your family?.	Yes	No	Do frightening thoughts keep coming back into your mind?	Yes	No
Did you ever have a nervous breakdown?	Yes	No	Do you often become suddenly scared for no good reason?	Yes	No
Did anyone in your family ever have a nervous breakdown?	Yes	No	Do you often break out in a cold sweat?	Yes	No
Were you ever a patient in a mental hospital (for your nerves)?	Yes	No			

Acknowledgements

Chiropractic care: I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Privacy Verification: I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Permission to contact: I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

X-ray Verification: I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the risks.

(females only)
Date of last menstrual period: _____

General Verification: To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature: _____ Date: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-ray. The particular diagnosis and treatment plan for my case have been explained to me.

I understand that the practice of chiropractic is not an exact science, that individuals respond differently to treatment, and that there are no guarantees of the result of any treatment. I understand that the examination and treatment involves certain risks and those risks have been explained or provided to me. I do not expect the doctor to be able to anticipate and explain all imaginable risks and/or contraindications, and I wish to rely on the doctor to exercise his judgment based on the facts known to be in my best interest during the course of my treatment. I understand that the doctor is a licensed chiropractor in the state of Texas and by such is licensed to employ objective or subjective means without the use of drugs, surgery, x-ray therapy or radium therapy for the purpose of ascertaining the alignment of the vertebrae, other joints and/or injured neuro-musculoskeletal structures to correct any subluxation, misalignment or impairment. Accordingly, I understand the practice of chiropractic is limited to diagnosing and re-adjusting the spinal vertebrae and/or extremity when they are misaligned, in order to help cure or resolve neuro-musculoskeletal symptoms that result from such a misalignment.

I understand any and all doctors employed by this office disclaim being able to treat me for any maladies or symptoms that I may be experiencing that may not be related to the injuries reported to the doctor. It is not expressed or implied in this office that the treatments offered by the doctor will specifically cure any symptoms I may be experiencing in any other part of my body.

I have read and understood the above consent for chiropractic treatments and care. I have also had the opportunity to ask questions regarding this consent and my treatment plan. Further, I understand all charges incurred at Health By Hands are ultimately my responsibility regardless of payment availability from another source. I am also aware that there is a missed appointment/cancellation policy: a variable non-refundable fee (consistent with the length of time scheduled for the visit) will be charged for each missed appointment or a cancellation that has not been received at least 24 hours prior to my appointment.

Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation. I therefore authorize examination and treatment to be performed at Health by Hands.

PATIENT'S NAME: (PLEASE PRINT) _____

PATIENT'S SIGNATURE: _____ DATE __/__/_____

Or NAME OF CUSTODIAL PARENT OR LEGAL GUARDIAN, ON BEHALF OF THE PATIENT:

(PLEASE PRINT) _____

PARENT / GUARDIAN SIGNATURE: _____ DATE __/__/_____

**NOTICES OF PRIVACY PRACTICES
(Effective April, 2003)****[Notice of Privacy, Page 1 of 2]**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, ALSO HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your health record

A record is made each time you are treated at our Clinic. Your injuries, evaluation, test results, diagnosis, treatment, and a plan of care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure it's accuracy, and enable you to relate to who, what, when, where and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. This Clinic is not required to accept your requests and you cannot request restrictions on uses or disclosures otherwise required by law. Your rights include being able to review or obtain a paper copy of your health information, and are given an account of all disclosures. You may also request communication of your health information be made by alternative means or to alternative locations in a confidential manner. This Clinic is required by law to accommodate reasonable request to receive communications of health information by alternative means or to alternative locations if you clearly state that disclosures of all or part of the information that could endanger you. This Clinic may require you to submit a written request for any of the documents or actions that you have a right to under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Our responsibilities

This Clinic is required by law to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with the respect to the information we collect and maintain about you. This Clinic is required to abide by the terms of this notice, as currently in effect, and to notify you if we are unable to grant your requested restrictions or locations. This Clinic reserves the right to change its practices and effect the new provisions with respect to all health information that it maintains (including such information that this Clinic had prior implementation of the new provisions).

Use and disclosure of your Health Information without your authorization

This Clinic may use and disclose your health information in order to provide "Treatment", obtain "Payment" and perform our "Health Care Operations", as well as other specific reasons detailed below:

- **Treatment** — information obtained by your provider in this Clinic will be recorded in your medical record and used to determine the course of treatment. This consists of you provider recording his/her own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as physicians.
- **Payment** — Your health care information will be used in order to receive payment for services rendered by this Clinic. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.
- **Health Care Operations** — The medical staff in this Clinic will use your health information to assess the care you received and the outcome of your cases compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.
- **Business Associates** — Some or all of your health information may be subject to disclosure through contracts for services to assist this Clinic in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this Clinic through the terms detailed in a written agreement.
- **Notification** — Your health record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.
- **Communications with Family** — Using best judgment, a family member, or close personal friend, identified by you, may be given health information relevant to your care and/or recovery.
- **Worker's Compensation** — This Clinic will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health** — This clinic is required by law to disclose your health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This Clinic is further required by law to report communicable diseases, injury, or disability.

NOTICES OF PRIVACY PRACTICES

[Notice of Privacy, Page 2 of 2]

- **Law Enforcement** — This Clinic may disclose your health information to the police or other law enforcement officials as required or permitted under state law or in response to a valid court, grand jury, or administrative subpoena.
- **Health Oversight Activities** — This Clinic may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with rules of government health programs, such as Medicare and Medicaid.
- **Victims of Abuse, Neglect, or Domestic Violence** — If this Clinic reasonably believes that you are a victim of abuse, neglect, or domestic violence, it may disclose your health information to the appropriate governmental authority, authorized by law to receive reports such as abuse, neglect, or domestic violence.
- **Judicial and Administrative Proceedings** — This Clinic may disclose your health information in the course of a judicial proceeding in response to a legal order or other lawful purpose.
- **As required by Law** — This clinic may use and disclose your health information when required to do so by any other law not already referred to in the proceeding categories.

Use or disclosure of your health information with written authorization

Any other use or disclosure of your health information, other than those listed above, will only be made with your written authorization. You may revoke your authorization at any time, except to the extent this Clinic used or disclosed your health information in reliance of your authorization.

To receive additional information or report a problem

For further explanation of this notice or any complaints about your Privacy rights, or how Chiropractic Health and Fitness has handled your health information please contact us at 817-640-0282. If nobody is available to answer your concerns please feel free to make an appointment for a personal conference in person or by phone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)

Parent's / Legal Guardian's Name (print)

Patient's / Legal Guardian's Signature

Date

Authorized Facility Signature Date

Date

HEALTH BY HANDS WELLNESS CENTER
2510 Little Rd, ARLINGTON, TEXAS 76016
PHONE 817-930-0600
FAX 817-451-1252