

Starwood Chiropractic

4851 Legacy Drive * Suite 307 * Frisco, Texas 75034 * (972) 377-3909

Patient Information

Name _____ Date _____

Address _____
First M. Last Preferred Name

City _____ State _____ Zip _____

Sex: M F Birthdate ___/___/___ Age _____
 Single Married Widowed Separated Divorced

Patient SS # _____

Occupation _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Spouse _____

Occupation _____

Whom may we thank for referring you?

Contact Information

Home Phone _____

Work Phone _____ Ext. _____

Other Phone _____

E-mail _____

IN CASE OF AN EMERGENCY, CONTACT:

Name _____

Phone _____

Insurance Information

Insured's Name _____

Insured's Birthdate ___/___/___

Relationship to Patient:

Same Person Spouse Parent Other

Insurance Company _____

I.D./Policy # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above listed insurance company and assign directly to Starwood Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship to Patient Date

Accident Information

If Condition Due to an Accident

Accident Date _____

Type Of Accident: Auto Work Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker's Comp Other

Attorney Name (if applicable) _____

Attorney Phone _____

Patient Condition

Height _____ Weight _____

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse?

Yes No Unknown

Rate the severity of your pain on a scale from 1 to 10

0-----5-----10

(no pain)

(severe pain)

Type of Pain:

Sharp Dull Throbbing Numbness

Aching Shooting Burning Tingling

Cramping Stiffness Swelling Other

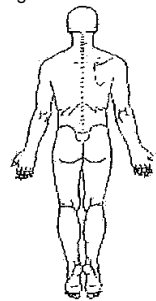
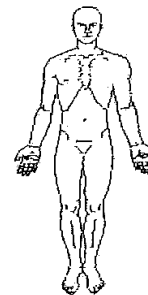
How often do you have this pain (is it constant or does it come and go)? _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Additional Comments Concerning Your Condition:

Mark an X on the picture where you continue to have pain, numbness, or tingling



Health History

What treatment have you already received for your condition? Chiropractic Services Medications Surgery
 Physical Therapy None Other _____

Name and telephone number of other doctor(s) who have treated you for your condition _____

Date of Last: Chiropractic Adjustment _____ Medical Appointment _____ Massage _____

Place a mark on "past", "present", or "never" to indicate if you have had any of the following:

<p><small>Past Present Never</small></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy Shots</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Angina</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breast Lump</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pains</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation or Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive Thirst</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fractures</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> General Fatigue</p>	<p><small>Past Present Never</small></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gout</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Herniated Disc</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lazy Eye</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Function</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Migraine Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscle Spasms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful/Frequent Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pinched Nerve</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pneumonia</p>	<p><small>Past Present Never</small></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Polio</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor Circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prosthesis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in Ears</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to Light</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tumors/Growths</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visual Disturbance</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Females Only</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Birth Control</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful Periods</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Currently Pregnant</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trying to Become Pregnant</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Miscarriage</p> </div>
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Please List All Surgeries and Major Injuries (fractures, motor vehicle accidents, etc.):

Medications

Allergies

Vitamins

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

LIFESTYLE

- Smoking
- Alcohol
- Coffee/Caffeine
- Water

Packs/Day _____

Drinks/Day _____

Cups/Day _____

Glasses/Day _____

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures. This includes examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to me, while employed by, working for, associated with, or serving as backup for the doctor of Starwood Chiropractic.

I have had an opportunity to discuss with the doctor and or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed

I have read the above explanation of the Chiropractic adjustment and related treatment. By signing below I stat that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having had the opportunity to ask about the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name

Patient/Legal Guardian Signature

Date