PRIOUX CHIROPRACTIC

7650 ANCHOR DRIVE, PORT ARTHUR, TX 77642

NEW PATIENT PAPER WORK

CASE HISTORY

Name: ______________________________ Date: __________

Address: ______________________________ City: __________

State: ________ Zip: ________ DOB: ____________ Age: _____ SSN# __________

Home #: ( ) ______________ Cell #: ( ) ______________

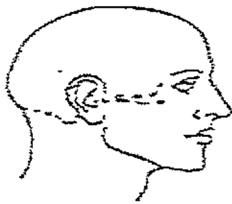
Work #: ( ) ______________ Emergency contact: ( ) ______________

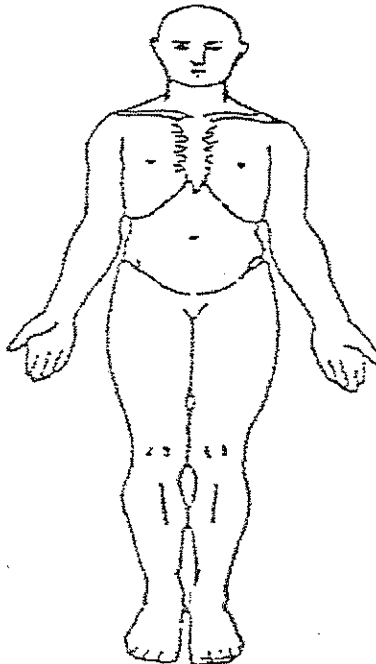
Primary Physician: ______________________ Phone #: ______________

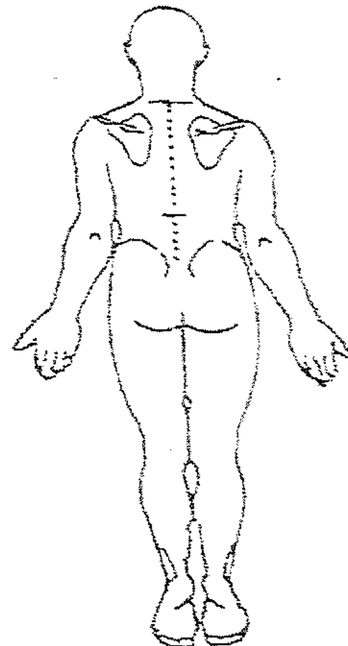
Referred by: ______________________ (family, friend, Facebook, Website, etc.)

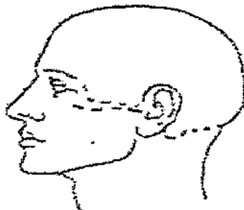
Are you in our office today because of a recent auto accident? Yes or No

WHERE IS THE PAIN/ PROBLEM LOCATED? Please mark on the pictures below.









Symptom Survey

List problems from most sever to least sever. Please be as specific as possible.

Problem #1.____

Location of pain:____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) **Pain is?** Mild Moderate Severe

Progression (circle): same, better, worse. **How often is the pain present?** Constant, 50-75%, 25-50%, less than 25%

When did you notice the problem? __________ **What happened**____________________

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other ________

Worse with (circle): sitting standing walking bending twisting lifting movement other ________

Quality of pain(circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes or No / where? ______________

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

Other ____________________ **did it help**? Yes or No

Problem #2.____

Location of pain:____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) **Pain is?** Mild Moderate Severe

Progression (circle): same, better, worse. **How often is the pain present?** Constant, 50-75%, 25-50%, less than 25%

When did you notice the problem? __________ **What happened**____________________

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other ________

Worse with (circle): sitting standing walking bending twisting lifting movement other ________

Quality of pain(circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes or No / where? ______________

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

Other ____________________ **did it help**? Yes or No

Patient Name: ______________________________

Date of Birth: ___/___/_______

Please list all vitamins and supplements:

Name Dose How often do you take?____

_____Please list all prior surgeries:

Type of Surgery	Date	Type of Surgery	Date

Please list all prior hospitalizations (other than for surgery):

Reason for hospitalization	Date	Reason for hospitalization	Date

Social History

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE – TYPE ______________ ☐ Rare ☐ occasional ☐ moderate ☐ daily

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _______ ☐ SMOKE ____ PACKS/ DAY FOR ___ YEARS
USE OF RECREATIONAL DRUGS: ☐ Never ☐ Quit – HOW LONG AGO? ________ TYPE ______________
☐ CURRENT USE – TYPE ______________ ☐ Rare ☐ occasional ☐ moderate ☐ daily

EMPLOYER: ______________________ OCCUPATION: ______________________
How much are you on your feet at work? ☐ 10% ☐ 25% ☐50% ☐75% ☐100%
DO OTHERS DEPEND UPON YOU FOR THEIR CARE? ☐ children – age(s) __________ ☐ Pet(s) – what kind? __________
☐ Elderly or disabled family members ☐ Other ______________________
EXERCISE: ☐ never ☐ rare ☐ occasional ☐ weekly ☐ several times a week ☐ daily
Types of exercise: ______________________

FAMILY HISTORY

Do you have a family history of: ☐ diabetes ☐ cancer ☐ heart disease ☐ high blood pressure
☐ stroke ☐ coronary artery disease ☐ thyroid disease ☐ rheumatoid arthritis
☐ other ______________________

Patient Name: ______________________________
Date of Birth: ____/____/_____

Your Medical History

Allergies: ☐ None Known ☐ Medications ______________________________
☐ Anesthesia ______________________ ☐ Foods ______________________
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other ______________________

Have you ever had any of the following?

Condition			Condition			Condition		
Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disease	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Other Conditions:								

OUR OFFICE ONLY

Blood pressure/vitals

Sitting: ______________________________ Zinc: good or deficient

Laying: ______________________________

Standing: ______________________________ Iodine: good or deficient

Breath holding: ______________ seconds.

Weight: __________ lbs.

Height: __________

Date: ____________________

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name ________________________________ Date ____________________

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

   No pain — Worst pain possible

   0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

   No interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

   No interference — Unable to carry out activity

   0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

   Not at all anxious — Extremely anxious

   0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

   Not at all depressed — Extremely depressed

   0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

   Have made it no worse — Have made it much worse

   0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

   Completely control it — No control whatsoever

   0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name ________________________________ Date ____________________

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

____
Examiner

OTHER COMMENTS: ____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

PRIOUX CHIROPRACTICE CENTER

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

TREATMENT: we will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: we may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing marketing, and fundraising activities, and conduction or arranging for the other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name an indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT. AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

______________________________ Signature of patient

________________ Date

______________________________ Print Name

INFORMED CONSENT FOR CHIROPACTIC TREATMENT

TO THE PATIENT: you have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctor of Chiropractic working at thus clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of my chiropractic treatment at all.

I understand that there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/ strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/ aggravation of spinal conditions)
- ☐ Increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other ________________________

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN____

____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

____
Print name

____
Signature of patient

____
Date signed

To be completed by the patient's representative:

____
Print name of patient

____
Print name of patient's representative

____
Signature of patient's representative

As: ________________________
Relationship/authority of patient's representative

____
Date signed

To be completed by doctor or staff:

________________________ ________________________
Witness to patient's signature Date

________________________ ________________________
Translated by date

PRIOUX CHIROPRACTIC CENTER
PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

- As our patient, you are responsible for all authorization/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance byyou, or your health insurance carrier. Payment for office services are due at the time of service. We will accept care credit, visa, MasterCard, discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company does not pay the practice within in a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and wi only require you to pay the copay at the time of service.
- If you have insurance coverage with a plan with which we do not have prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services of referrals: however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collections fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- The attached page will explain further on fee due for re-exam services.

Signature of Patient/ Responsible Party: ____

Printed name of Patient/ Responsible Party: ____________________________ date: ____________

PRIOUX CHIROPRACTIC CENTER
RE-EXAM INFORMATION LETTER

This letter is to inform you that we perform exams as part of our thorough protocol. The exams are to explain findings and compare previous exams to show improvement.

Your insurance does not cover exams and treatments performed on the same day. Because of this, you will be responsible for $35.00 per exam.

There are usually 4 exams performed during the treatment until you will reach wellness status. We will still bill insurance, and if they pay, we will refund that amount.

By signing, you agree to this letter Signed: ____