PRIOUX CHIROPRACTIC

7650 ANCHOR DRIVE, PORT ARTHUR, TX 77642

NEW PATIENT PAPERWORK

CASE HISTORY

Name: _____ Date: _____

Address: _____ City: _____

State: ____ Zip: _____ DOB: _____ Age: ____ SSN#: _____

Home #: ( ) _____ Cell #: ( ) _____ Work #: ( ) _____

Occupation: _____ Email: _____

Primary Physician: _____ Phone #: _____

Marital status: S M D W Spouse name: _____ # of children & ages: _____

Referred by: _____ (Family, Friend, Facebook, Website, etc.)

PAST HEALTH HISTORY

Sports Injuries Auto Accidents Surgeries Scars

Describe:

_____

_____

_____

CURRENT HEALTH HISTORY

Do you exercise? Y___ N___ if yes, describe: _____

Which vitamins do you take? _____

_____

Do you sleep well? _____ Do you have mental stress? _____ Do you smoke? _____

Do you drink alcohol? _____ Do you drink diet drinks? _____

SYMPTOMS & ILL HEALTH

What pain causes you to come into our office? _____

_____

How long have you been experiencing this pain? _____

_____

Was there a specific cause? Y or N Describe: _____

_____

HOW BAD IS THE PAIN? ____ OCCASIONAL ____ FREQUENT ____ CONSTANT

What makes the pain worse? _____

_____

Is the pain interfering with your life? Y or N Describe: _____

_____

What helps make this pain better? _____

_____

What else have you done to treat the pain? _____

_____

Does the pain happen only at a certain time of the day? Y or N, Describe: _____

_____

Does the pain travel to any other area? _____

_____

What problems do you take medication for, if any? _____

_____

REVIEW OF SYMPTONS

Please indicate whether you have dysfunction in the following systems with a check:

____ Skin/Breast ____ Eyes/Ears/Nose/Mouth/Throat ____ Cardiovascular ____ Respiratory

____ Gastrointestinal ____ Genitourinary ____ Musculoskeletal ____ Neurologic/Psychiatric

CRANIAL NERVES

Do you have vision problems? Y or no, describe: _____

_____

Do you have jaw problems? Y or n, describe: _____

_____

Do you have numbness in your face? Y or n describe: _____

_____

Do you have hearing loss? Y or n describe: _____

_____

Do you have any sores in your mouth or tongue? Y or n describe: _____

_____

I authorize Prioux Chiropractic Center to send examination findings and progress reports to my primary physician to coordinate my treatment plan.

SIGNED: _____

_____

NUTRITION TESTING

OFFICE USE ONLY

BLOOD PRESSURE:

L: / ♡

S: / ♡

ZINC TEST:

TASTE: _____

TEMPURATURE: _____

BREATH HOLDING:

TIME: _____

IODINE TEST:

DURATION: _____

OXYGEN TEST: _____

HEIGHT: _____ WEIGHT: _____ FAT % _____ HYDRATION % _____

MUSCLE % _____ BONE % _____ CALORIE INTAKE: _____

FUNCTIONAL RATING INDEX

Patient name_____Date_____

This questionnaire will give your provider information about how your condition affects your everyday life. Please answer every section by marking the one statement that most that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY

(0) I have no pain at the moment.
(1) The pain is very mild at the moment.
(2) The pain comes and goes and is moderate.
(3) The pain is fairly severe at the moment.
(4) The pain is very severe at the moment.
(5) The pain is worst imaginable at the moment.

SLEEPING

(0) I have no trouble sleeping
(1) My sleep is slightly disturbed (less than one hour sleepless).
(2) My sleep is mildly disturbed (1-2 hours sleepless).
(3) My sleep is moderately disturbed (2-3 hours sleepless).
(4) My sleep is greatly disturbed (3-5 hours sleepless).
(5) My sleep is completely disturbed (5-7 hours sleepless).

READING

(0) I can read as much as I want with no pain.
(1) I can read as much as I want with slight neck pain.
(2) I can read as much as I want with moderate neck pain.
(3) I cannot read as much as I want because of severe neck pain
(4) I can hardly read at all because of sever neck pain.
(5) I cannot read at all because of neck pain.

CONCENTRATION

(0) I can concentrate fully when I want with no difficulty.
(1) I can concentrate fully when I want with slight difficulty.
(2) I have a fair degree of difficulty concentrating when I want.
(3) I have a lot of difficulty concentrating when I want.
(4) I have a great deal of difficulty concentrating when I want.
(5) I cannot concentrate at all.

WORK

(0) I can do as much work as I want
(1) I can only do my usual work but no more.
(2) I can only do most of my usual work but no more.
(3) I cannot do my usual work.
(4) I can hardly do any work at all. I cannot do any work.
(5) I cannot do any work at all.

PERSONAL CARE

(0) I can look after myself normally without causing extra pain.
(1) I can look after myself normally, but it causes extra pain.
(2) It is painful to look after myself and I am slow and careful.
(3) I need some help, but I manage most of my personal care.
(4) I need help every day in most of my self-care.
(5) I do not get dressed, I wash with difficulty and stay in bed.

LIFTING

(0) I can lift heavy weight without extra pain.
(1) I can lift heavy, but it causes extra pain.
(2) Pain prevents me lifting heavy weight off the floor, but I manage if they are conveniently positioned (e.g. on a table)
(3) Pain prevents me from lifting heavy weight if they are conveniently position.
(4) I can only lift very light weight.
(5) I cannot lift or carry anything at all.

DRIVING

(0) I can drive my car without any pain.
(1) I can drive my car as long as I want with slight pain.
(2) I can drive my car as long as I want with moderate pain.
(3) I cannot drive my car as long as I want because of moderate pain.
(4) I can hardly drive at all because of severe pain.
(5) I cannot drive my car at all because of severe pain.

SOCIAL LIFE

(0) I can engage in all my recreation activities without pain.
(1) I can engage in all my usual activities with some pain.
(2) I am only able to engage in most but not all my usual activities because of pain.
(3) I can hardly do any recreation activities because of pain.
(4) I cannot do any recreation activities at all.

HEADACHE

(0) I have no headache at all.
(1) I have slight headaches which come infrequently.
(2) I have moderate headaches which come infrequently.
(3) I have moderate headaches which come frequently.
(4) I have severe headaches which come frequently
(5) I have headaches almost all the time.

SITTING

(0) I can sit in any chair as long as I like.
(1) I can only sit in my favorite chair as long as I like
(2) Pain prevents me from sitting more than 1 hour.
(3) Pain prevents me from sitting longer than ½ hour.
(4) Pain prevents me from sitting longer than 10 minutes.
(5) I avoid sitting because it increases pain immediately.

WALKING

(0) I have no pain while walking.
(1) I have some pain while walking but it doesn't increase with distance.
(2) I cannot walk more than 1 mile without increasing pain.
(3) I cannot walk more than ½ mile without increasing pain.
(4) I cannot walk more than ¼ mile without increasing pain.
(5) I cannot walk at all without increasing pain.

ENERGY

(0) I have an abundance of energy
(1) I have more energy than tiredness.
(2) I am just as tired as I have energy.
(3) I am more tired than I have energy.
(4) I completely exhausted.

TOTAL: _____

STANDING

(0) I can stand as long as I want without pain.
(1) I have some pain while standing but it does not increase with time.
(2) I cannot stand for longer than 1 hour without increasing pain.
(3) I cannot stand for longer than ½ hour without increasing pain.
(4) I cannot stand for longer than 10 minutes without increasing pain.
(5) I avoid standing because pain immediately.

DIGESTION

(0) I have good digestion and do not have to limit foods.
(1) I have good digestion, only if I avoid certain foods.
(2) I need over-the-counter medicine to good digestion.
(3) I take prescription drugs to have good digestion.
(4) I have poor digestion, and nothing helps.

CHANGING DEGREE OF PAIN

(0) My pain is rapidly getting better.
(1) My pain fluctuates but overall is definitely getting better.
(2) My pain seems to be getting better but improvement is slow.
(3) My pain is neither getting better or worse.
(4) My pain is gradually worsening.
(5) My pain is rapidly worsening.

DOCTOR PATIENT RELATIONSHIP IN CHIROPRACTIC

(Please initial after reading each statement)

CHIROPRACTIC

It is very important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on the environment, underlying causes. Physical and spinal conditions. It is very important to understand what to expect from chiropractic healthcare services.

Initials: _____

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of vertebral subluxation syndrome (vss) or vertebral subluxation complexes (vsc). When such vss and vsc complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that the spinal alignment allows nerve transmission throughout the body and gives an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise specific results. This depends upon the inherent recuperative powers of the body.

Initials: _____

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the vss and the vsc, they are not internal medicine specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as the nature of his/her total condition. Your doctor of chiropractic may express an opinion to whether you should take this step, but you are responsible for the final decision.

Initials: _____

INFORMED CONSENT OF CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contradicted. Again, it is the responsibility of the patient to make it known of any latent pathological defects, illness, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The doctor of chiropractic provides a specialized non-duplication health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

Initials: _____

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time scheduled or efficiency of the chiropractic procedures.
sometimes the response is phenomenal.

In most cases, there is more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to the chiropractic care may be under control or be helped through medical science. The fact is that science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

Initials: _____

TO THE PATIENT

Appointment must be cancelled 24 hours in advance; patients who do not call to cancel will be charged the full price of $50.00. please discuss any questions with the doctor before signing this statement policy. Patient with medical emergencies or unforeseen circumstances will be rescheduled at no charge.

Initials: _____

I have read, and understand the foregoing.

_____ _____

Patient Signature Date

PRIOUX CHIROPRACTIC CENTER
PATIENT CONSENT FORM

_____, hereby states that by signing the consent, I acknowledge and agree as follows.

1. The privacy notice has been provided to me prior to my signing this consent. The privacy notice includes a complete description of the uses and/or disclosures of my protected health information ("phi) necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for the treatment and to carry out its health care operations. The practice explained to me that the privacy notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the privacy notice prior to my signing the consent.
2. The practice reserves the right to change its privacy practices that are described in its privacy notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the practice;
   a) a postcard to be mailed to me at the address provided by me; B) telephoning my home/cell/work and leaving a message on my answering machine or with the individual answering the phone; or c) by email if possible.
4. The practice may use or disclose my phi (which contains information about my health or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.
5. I understand that I have a right to request that the practice restricts how many phi is used or disclosed to carry out treatment, payment or health care operations. However the practice is not required agree to any restrictions that I have requested. If the practice agrees to a requested restriction then, the restriction is binding on the practice.
6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke my consent, in writing, at any time for all future transactions, with understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.
8. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures to me above and contained in the privacy notice, the practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Printed Name of Patient | Patient Signature

_____ _____

Date signed | Witness signature

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 by you, 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. In other words, you agree to have your insurance company pay the doctor directly. 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 will 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 a 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. Therefor, 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 or 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, collection 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: _____