Welcome to Lavaca County Chiropractic

Patient Information

Date _____

Patient Name _____

SSN _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age ____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ____ years

Occupation _____

Employer/School _____

Spouse/Parent Name _____

SSN _____ Birthdate _____

Spouse/Parent Employer _____

Referral Source
☐ Friend/Family ☐ Insurance ☐ Website ☐ Internet
☐ Yellow Pages ☐ Other _____

Whom may we thank for referring you? _____

Insurance

Policy Holder's Name _____

Relationship to Patient _____

Birthdate _____ SSN _____

Insurance Co. _____

Do you have Medicare? ☐ Yes ☐ No

Is patient covered by additional insurance? ☐ Yes ☐ No

AUTHORIZATION, ASSIGNMENT & RELEASE

By signing below, I authorize Lavaca County Chiropractic, PLLC to release medical records required by my insurance company(ies). I authorize my insurance company(ies) to pay benefits directly to Lavaca County Chiropractic, PLLC and I agree that a reproduced copy of this authorization will be as valid as the original.

I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred.

I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____

IN CASE OF EMERGENCY (individual you do NOT live with)

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney/Adjuster Name (if applicable)

_____

Attorney/Adjuster Phone (____) _____

Patient Condition

Reason for Visit _____

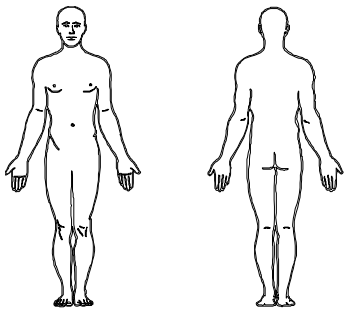
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

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

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ 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 ☐ Other

1400 N. Texana | Suite A | Hallettsville, Texas 77964 | Ph: (361) 798-4300 | Fax: (361) 798-4314

Health History

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

☐ Other _____

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

Date of Last: Physical Exam _____ Spinal Exam _____ Blood Test _____

Spinal X-Ray _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan _____ Other _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

If so, describe _____

Age of mattress _____ ☐ Comfortable ☐ Uncomfortable

Do you wear ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch Supports

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Injuries/Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Please check if you have **ever** had any of the following:

☐ AIDS/HIV	☐ Cataracts	☐ Hernia	☐ Mumps	☐ Scarlet Fever
☐ Alcoholism	☐ Chicken Pox	☐ Herniated Disc	☐ Osteoporosis	☐ Stroke
☐ Allergy Shots	☐ Diabetes	☐ Herpes	☐ Pacemaker	☐ Suicide Attempt
☐ Anemia	☐ Diphtheria	☐ High Cholesterol	☐ Parkinson's	☐ Thyroid Problem
☐ Anorexia	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Tonsilitis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Pinched Nerve	☐ Tuberculosis
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Pneumonia	☐ Tumor
☐ Asthma	☐ Fever Blisters	☐ Malaria	☐ Polio	☐ Typhoid Fever
☐ Breast Lump	☐ Glaucoma	☐ Measles	☐ Prostate Problem	☐ Ulcers
☐ Bronchitis	☐ Gonorrhea	☐ Migraine	☐ Prosthesis	☐ Vaginal Infection
☐ Bulimia	☐ Gout	☐ Miscarriage	☐ Psychiatric Care	☐ Venereal Disease
☐ Cancer	☐ Heart Disease	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Chorea	☐ Hepatitis	☐ Multiple Sclerosis	☐ Rheumatoid	☐ Other _____

Medications	Allergies	Vitamins/Herbs/Supplements

Review of Systems

Please check if you are currently experiencing any of the following symptoms.
Please check NONE if you are not.

GENERAL
☐ *NONE*
- ☐ Chills
- ☐ Convulsions
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Sweats
- ☐ Weight Loss
- ☐ Weight Gain

MUSCLE & JOINT
☐ *NONE*
- ☐ Arthritis
- ☐ Bursitis
- ☐ Low Back Pain
- ☐ Neck Pain/Stiffness
- ☐ Pain between Shoulder Blades

Pain or Numbness in:
- ☐ Shoulder
- ☐ Arm
- ☐ Elbow
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

- ☐ Painful tail bone
- ☐ Poor Posture
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Swollen Joints

GASTROINTESTINAL
☐ *NONE*
- ☐ Belching or Gas
- ☐ Colitis
- ☐ Colon Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Gall Bladder problems
- ☐ Hemorrhoids
- ☐ Intestinal Worms
- ☐ Jaundice
- ☐ Liver problems
- ☐ Nausea
- ☐ Pain over Stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting Blood

RESPIRATORY
☐ *NONE*
- ☐ Chronic cough
- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Spitting up Blood
- ☐ Spitting up Phlegm
- ☐ Wheezing

NEUROLOGICAL
☐ *NONE*
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Loss of balance
- ☐ Migraines
- ☐ Stroke
- ☐ Tremors

EARS, NOSE & THROAT
☐ *NONE*
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear Noises / Tinnitus
- ☐ Enlarged Glands
- ☐ Enlarged Thyroid
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Sinus Infection
- ☐ Sore Throat
- ☐ Tonsillitis

SKIN
☐ *NONE*
- ☐ Boils
- ☐ Bruise Easily
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Rash

CARDIOVASCULAR
☐ *NONE*
- ☐ Chest Pain
- ☐ Hardening of Arteries
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Poor circulation
- ☐ Rapid Heart Beat
- ☐ Slow Heart Beat
- ☐ Swelling in Ankles

EYES
☐ *NONE*
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Failing Vision

PSYCHIATRIC
☐ *NONE*
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Panic Attacks
- ☐ Alcohol/Drug Dependence

GENITOURINARY
☐ *NONE*
- ☐ Bed wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Prostate Problems
- ☐ Pus in Urine

WOMEN ONLY
☐ *NONE*
- ☐ Congested Breasts
- ☐ Cramps or backache
- ☐ Excessive Menstrual Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Menopausal symptoms
- ☐ Painful Menstruation
- ☐ Vaginal Discharge

Please describe/explain any treatment you have had or are currently receiving for the symptoms checked above.
Please also note any other health problems you have that may not have been covered on this form.

_____

_____

_____

_____

Thank You!