ROSE FAMILY CHIROPRACTIC
WELLNESS CENTER LLC

368 N Union St. New Braunfels, Texas 78130
Phone: (830) 629-3101 Fax: (830) 626-8245

Patient Information:

Date: _____ Patient #:_____ Doctor: _____

Name: _____ SS #:_____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell Phone: _____

Age: _____ Birth date: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

How many children? _____

Emergency Contact: _____ Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

May we have your permission to update your medical doctor regarding your care at this office?

(Please initial) _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: _____

Date symptoms first appeared or date of accident: _____

Have you ever had the same or similar condition in the past? Yes No If yes, when & please describe: _____

_____

PAST MEDICAL HISTORY:

Do you have a history of stroke, TIA or hypertension? (Please be specific)_____

_____

Have you had any surgeries? (Spinal such as a fusion or non-spinal such as an appendectomy) Yes No If yes, describe:

_____

_____

_____

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Have you ever been diagnosed or currently suffer with any of the following: (Please place a check by conditions that apply to you)

__ Broken or Fractured bones	__Osteoarthritis	__Eating disorder
__Circulatory Problems	__Pacemaker	__Alcoholism
__Rheumatoid Arthritis	__Strokes	__Drug Addiction
__Seizures/Convulsions	__Cancer	__HIV/AIDS positive
__Congenital Disease	__Ruptures	__Diabetes
__Hemophilia/Excessive bleeding	__Coughing blood	__Depression
__High/Low Blood Pressure	__Epilepsy	__Obesity
__Lupus	__Psoriasis	__Hyper/hypothyroidism

Please elaborate on any condition you marked: _____
_____

Have you had any major illnesses/infections, injuries, falls or auto accidents? Women, please include information about childbirth (including dates): _____
_____

Have you been treated for any health condition by a physician in the last year? Yes No If yes, describe:
_____

What medications or drugs are you currently taking? _____
_____

Do you have any allergies to any medications? _____

SOCIAL HISTORY

Do you drink alcoholic beverages? **Y** **N** If so, how much per week? _____
Do you use any tobacco products? **Y** **N** If so, how much per week? _____
Do you take vitamin supplements? **Y** **N** If so, please list _____
Do you consume caffeine? **Y** **N** If so, how much per day? _____
Do you exercise? **Y** **N** If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting_____ Sitting_____ Bending _____Working at a Computer_____

FAMILY HISTORY

Father: living_____ deceased_____ Current age if still living: _____ Cause of death and age at death if deceased: _____
Mother: living_____ deceased_____ Current age if still living: _____ Cause of death and age at death if deceased: _____

Check here if applicable to you: _____ As an adopted child, little is known of birth parents or family.

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FAMILY DISEASES (check if applicable and indicate whether family is **F**ather, **M**other, **S**ister, **B**rother):

____Tuberculosis	____Cancer	____Mental Illness
____Diabetes	____Asthma	____Heart Disease
____Stroke	____Kidney Disease	____Lung Disease
____Arthritis	____Liver Disease	____Autoimmune Disease

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company: _____

AUTHORIZATION & RELEASE:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with the personal physicians and other healthcare providers and payors to secure the payment of benefits. I also understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

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SUMMARY

What is your primary symptom? _____

When did you first notice this problem? _____
If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Please circle the answer that best describes your current condition:
Has is become worse recently? Yes No Same Better Gradually Worse

How frequent is the condition? Constant Intermittent Night Only During certain activity

How long does it last? All Day Few hours Minutes

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other_____

Does the pain travel anywhere? _____

Is there anything you can do to relieve your symptoms? Yes No If yes, describe _____
_____ If no, what have you tried that does not alleviate your pain? _____
_____

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Driving
Walking Exercising Other_____

How would you rate your pain right now?

No pain _____Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Are there any other symptoms that you are currently experiencing? Yes No
If yes, please explain _____

What can you do to relieve the pain? _____

Does anything make it worse? _____

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

Doctor's Signature: _____ Date: _____

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Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by Dr. Rose and/or other licensed doctors of chiropractic who now or in the future work at the clinic of office listed below or any other office of clinic.

I have had an opportunity to discuss with the doctor of chiropractic (Dr. Korey Rose or Dr. Kelsey Rose) and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treament, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. 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 Signature _____ Date _____

Witness Signature _____ Date _____