PATIENT INFORMATION

Date _____ *Fecha*

Home Phone _____ *Tel. Casa*

Name _____ *Nombre* Soc Sec # _____ *Seguro Social* Work Phone _____ *Tel. Trabajo*

Address _____ *Dirección* City _____ *Ciudad* State _____ *Estado* Zip _____ *Codigo postal* Sex M ○ F ○ *Sexo*

Age ___ *Edad* Birthdate ___ ___ *Fecha d' nacimiento* Single ○ *Soltero/a* Married ○ *Casado/a* Date your pain began ___ ___ *Fecha del comienzo de su dolor* Did it occur suddenly ○ or gradually ○

Patient Employed by _____ *Paciente empleado por* Occupation _____ *Ocupación* Number of years doing current job ____ *Cuantos años tiene en este trabajo*

Whom may we thank for referring _____ *A quien se le agradecerá por referirlo/a?* Phone _____ *Teléfono*

In case of emergency who should be notified? _____ *En caso de emergencia a quien se le notificará?* Relationship _____ *Relación* Phone _____ *Teléfono*

PRESENT SYMPTOMS/ *Syntomas presentes*

CIRCLE WHICH APPLIES
Circule el qué aplica

Pain *Dolor*	Stiffness *Tieso*	Tingling *Hormigueo*	
☐ P	☐ S	☐ T	Neck *Cuello*
☐ P	☐ S	☐ T	Mid back *Espalda*
☐ P	☐ S	☐ T	Low back *Cintura*
☐ P	☐ S	☐ T	Shoulder *Hombro*
☐ P	☐ S	☐ T	Arm *Brazo*
☐ P	☐ S	☐ T	Hand *Mano*
☐ P	☐ S	☐ T	Hip *Cadera*
☐ P	☐ S	☐ T	Knee *Rodilla*
☐ P	☐ S	☐ T	Leg *Pierna*
☐ P	☐ S	☐ T	Foot *Pie*
☐ P	☐ S	☐ T	Chest *Pecho*
☐ P	☐ S	☐ T	Head *Cabeza*
P ☐ P	☐ S	☐ T	Abdominal *Estómago*

ADDITIONAL COMPLAINTS

- ☐ Headache *Dolor de cabeza*
- ☐ Tension *Tensión*
- ☐ Dizziness *Mareos*
- ☐ Nervousness *Nerviosismo*
- ☐ Fatigue *Fatiga*
- ☐ Insomnia *Insomnio*
- ☐ Difficulty breathing *Dificultad al respirar*
- ☐ Irritability *Irritable*
- ☐ Muscle spasm *Tensión muscular*

AGGRAVATED BY

- ☐ Lifting *Levantarse*
- ☐ Bending *Agacharse*
- ☐ Standing *Pararse*
- ☐ Walking *Caminando*
- ☐ Sitting *Sentarse*
- ☐ Lying down *Acostarse*

HISTORY OF COMPLAINT/ *Queja historial*

Other symptoms than above _____ *Otros síntomas no mencionados*

Have you lost time from work? Yes ○ No ○ How many days lost? ___ Dates from _____ Thru _____
A perdido tiempo en su trabajo Si No Cuántos días ha perdido Desde la fecha de Hacia

Have you gone to the emergency room for this condition? Yes ○ No ○ Date _____ Where _____
A hido al cuarto de emergencia por esta condición?(estado) Si No Fecha Donde

Have you been hospitalized for this condition? Yes ○ No ○ Date _____ Which hospital _____
A usted sido hospitalizado por esta condición (estado) Si No Fecha Que hospital

Have you seen any other doctors for this condition? Yes ○ No ○ Date _____ Dr. _____
A visto algún otro doctor/a por esta condición (estado) Si No Fecha Doctor

Address _____ *Dirección* City _____ *Ciudad* State _____ *Estado* Zip _____ *Codigo Postal* Phone _____ *Teléfono*

ACCIDENT INFORMATION/ *Información sobre del accidente*

Date of accident _____ *Fecha del accidente* Time _____ *Tiempo* ○ Am ○ Pm *Am Pm*

City _____ *Ciudad* # of persons in your vehicle ___ *Número de personas en su vehículo*

Were you the ○ driver ○ passenger ○ Pedestrian
Usted era el conductor pasajero peatón

Did your vehicle strike another vehicle after impact ○ Yes ○ No
Despues del impacto, su vehículo choco a otro vehículo? Si No

How many times was your vehicle struck ____
Cuantas veces recibió el impacto su vehículo?

You were hit from the ○ rear ○ front ○ right side ○ left side
Recibió el impacto por: atras enfrente lado izquierdo lado derecho

Were you prepared for the impact ○ Yes ○ No
Estaba preparado/a para el impacto? Si No

Who was cited ○ You ○ The driver of your vehicle ○ The driver of the other vehicle
Quien fue citado Usted El conductor de su vehículo El otro conductor del vehículo

How fast were you going _____
Que tan rapido iva

You were headed ○ South ○ North ○ East ○ West
Usted se dirigia : Sur Norte Este Oeste

on _____ ○ St ○ Ave ○ Rd in _____
en Calle Ave Rd en

Describe your symptoms immediately after the accident:
Describa los síntomas inmediatamente del accidente:

_____

_____

INSURANCE INFORMATION/ *Información sobre la aseguranza*

Insurance company name (of your vehicle)_____ Phone_____
Nombre de la compañia de aseguranza de su vehiculo *Teléfono*

Insured's name_____ Phone_____
Nombre del asegurado *Teléfono*

Address_____ City_____ State_____ Zip_____
Dirección *Ciudad* *Estado* *Codigo Postal*

Adjustor_____ Claim #_____ Policy 3_____
Agente *Número de demanda* *Número de poliza*

Have you contacted the insurance company? ◯ Yes ◯ No Date_____ Who did you speak with_____
Se a comunicado con su aseguranza? *Si* *No* *Fecha* *Con quien hablo*

Have you been contacted by the insurance compan ? ◯ Yes ◯ No Date_____ Who did you speak with_____
La aseguranza se a comunicado con usted ? *Si* *No* *Fecha* *Con quien hablo*

OTHER VEHICLE INSURANCE INFORMATION/ *Información sobre el otro conductor*

Insurance company's name_____ Phone_____
Nombre de la compañia de aseguranza *Teléfono*

Insured's name_____ Phone_____
Nombre del asegurado *Teléfono*

Driver's name_____ Phone_____
Nombre del conductor *Teléfono*

Address_____ City_____ State_____ Zip_____
Dirección *Ciudad* *Estado* *Codigo postal*

Adjustor_____ Claim #_____ Policy 3_____
Agente *Número de demanda* *Número de poliza*

Have you contacted the insurance company? ◯ Yes ◯ No Date_____ With whom did you speak_____
Se a comunicado con su aseguranza ? *Si* *No* *Fecha* *Con quien hablo*

Have you been contacted by the insurance company? ◯ Yes ◯ No Date_____ with whom did you speak_____
La aseguranza se a comunicado con usted ? *Si* *No* *Fecha* *Con quien hablo*

GROUP HEALTH INSURANCE INFORMATION/ *Aseguranza de Salud*

Company's name_____ Phone_____
Nombre de la compañia *Teléfono*

Insured's name_____ Phone_____
Nombre del asegurado *Teléfono*

Address_____ City_____ State_____ Zip_____
Dirección *Ciudad* *Estado* *Codigo Postal*

(If applicable) Group #_____ Policy #_____ Plan #_____
(Si aplica) *Grupo número* *Poliza número* *Plan número*

ATTORNEY INFORMATION/ *Information sobre el abogado*

Attorney's name_____ Phone_____
Nombre del abogado/a *Teléfono*

Address_____ City_____ State_____ Zip_____
Dirección *Ciudad* *Estado* *Codigo Postal*

ASSIGNMENT OF BENEFITS/ *Beneficios de asignación*

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsable for
Yo entiendo claramente y estoy de acuerdo que todos los servicios que se me hagan sean cobrados directamente a mi; yo personalmente me

payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me
hago responsable por el pago. Tambien entiendo que si yo paro o suspendo mi tratamiento y cuidado de los servicios profesionales hacia mi per-

will be immediately due and payable.
sona seran inmediatamente pagados.

Patient's Signature_____ Date_____
Firma del paciente *Fecha*

CONSULTATION
Consulta

Name *Nombre* _____ Date *Fecha* _____

ONSET/ Em feza

When did your pain begin? *Cuándo empezó su dolor?* Date *Fecha* _____

- ☐ Same day of the accident/injury *El dia del accident Mastimadura*
- ☐ The next day *El dia siguiente*
- ☐ Two or three days later *Dos o tres dias despues*

Have you had any previous accidents? ○ Yes ○ N *Si N* ○ When? *Cuando?*
A tenido algún accidente anteriormente?

Have you ever had the same/similar symptoms? ○ Yes ○ No
A tenido el mismo slntoma anteriormente? Si No

PROVOKE/QUALITY/ Calidad

What makes the pain worse?
Que hace peor su dolor?

- ☐ Bending *Agacharse*
- ☐ Sitting *Sentarse*
- ☐ Walkin *Caminando*
- ☐ Standing *Pararse*
- ☐ Lifting *Levantando*
- ☐ Driving *Manejando*

Are you sleeping comfortably? ○ Yes ○ No Why n t?
Esta dormiendo cómodo/a Si No Porqué no?

Describe your pain EX: ☐ Sharp ☐ Dull ☐ Ache
Describa su dolor Por ej: Agudo Liviano Dolor

What have you done for relief?
Que ha hecho para mejorarse?

- ☐ Ice *Hielo*
- ☐ Heat *Calor*
- ☐ Rest *Descanso*
- ☐ Exercise *Ejercicio*

Are you taking medication for pain? ○ Yes ○ No
Esta tomando medicamento para el dolor? Si No

RADIATING/ Radiando

Does any pain radiate down your arms/legs? ○ Yes ○ No
El dolor baja hacia sus piernas o brazos? Si No

Arm/s *Brazo* ☐ Right *Derecho* ☐ Left *Izquerdo* ☐ Both *Ambos*
Leg/s *Pierna* ☐ Right *Derecha* ☐ Left *Izquerda* ☐ Both *Ambas*

SITE/ Localidad

Which area hurts worse? *Cual es la area con peor dolor*

- ☐ Neck *Cuello*
- ☐ Mid back *Espalda*
- ☐ Low back *Cintura*
- ☐ Arms *Brazos*
- ☐ Legs *Piernas*
- ☐ Head *Cabeza*

TIMING/ Frequencia

When is your pain worse? *Cuando es el dolor más severo?*
☐ Mornings *Por las mañanas* ☐ Evenings *Las tardes*

How frequent is your pain? *Que tán frequente es su dolor?*
☐ Constant *Constante* ☐ Intermittent *Intermitente*

PREVIOUS CARE/ Cuidado previo

Have you seen any other doctors for this condition? ○ Yes ○ No
A visto a otros doctores por esta condición? Si No

Who? *Quién* Dr _____ Which specialty? *Que especialidad?*

- ☐ DC *Quiropráctico*
- ☐ MD *Medico*
- ☐ DO *Osteopata*
- ☐ Therapist *Terapeuta*

Where were you seen? *Dónde fue usted visto?* _____

What was done? *Que le hicieron?*

- ☐ X-rays *Radiografias*
- ☐ Medication *Medicamento prescrito*
- ☐ Examination *Examen*
- ☐ Treatment *Tratamiento*

WORK STATUS/ Trabajo

Are you currently working? ○ Yes ○ No ○ Full ○ Part time
Esta actualmente trabajando? Si No tiempo completo/Medio

Is the current accident/injury affecting your work? ○ Yes ○ No
El accidente o lastimadura está afectando su trabajo? Si No

Which activities? ☐ Sitting ☐ Bending ☐ Lifting
Que actividades Sentarse Agacharse Levantando

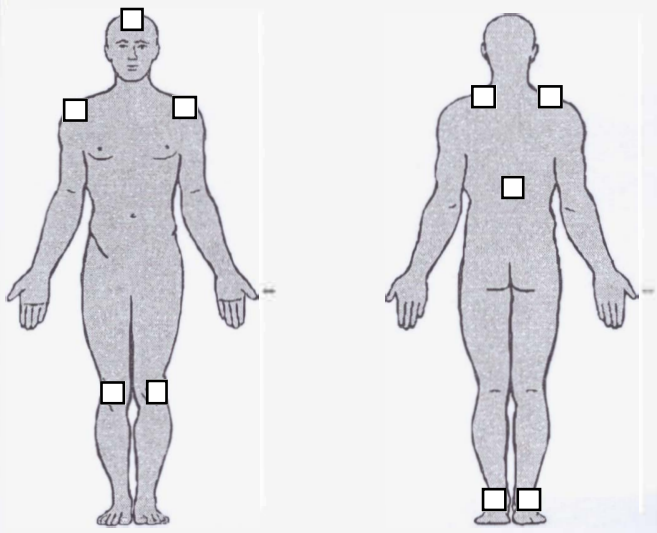
DISABILITY/ Incapacidad

Are you currently on disability? ○ Yes ○ No
Esta actualmente incapacitado? Si No

If yes, When did your disability begin _____
Si es sí. cuándo empezó su incapacidad

Is light duty available at your work? ○ Yes ○ No
Hay alguna actividad más liviana en su trabajo? Si No

MARK YOUR AREAS OF PAIN BELOW/ Marque las areas de dolor



In-Line Chiropractic Care P.A.
1919 North Loop West Ste. 180
Houston, TX 77008

Confidential Patient Case History

Dear Patient: Please complete questionnaire to help us determine whether or not chiropractic care is right for you. If we do not sincerely believe your condition will respond satisfactorily we will not accept your case. THANK YOU.

Please check the appropriate box for any of the following which you now have or had previously.

THIS IS A CONFIDENTIAL HEALTH REPORT

GENERAL

- ☐ Alcoholism
- ☐ Allergy
- ☐ Anemia
- ☐ Appendicitis
- ☐ Cancer
- ☐ Chills
- ☐ Chorea
- ☐ Cold Sores
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Fever Blister
- ☐ Goiter
- ☐ Gout
- ☐ Headache
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Malaria
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Numbness
- ☐ Nervousness
- ☐ Neuralgia
- ☐ Pleurisy
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Venereal Disease

Muscle & Joints

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Hernia
- ☐ Low Back Pain
- ☐ Neck Pain or Stiffness

Pain or Numbness in:

- ☐ Arms
- ☐ Elbows
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Knees
- ☐ Legs
- ☐ Painful Tailbone
- ☐ Poor Posture
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Swollen Joints

Gastro-Intestinal

- ☐ Belching or Gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Distension of Abdomen
- ☐ Ulcers

Cardio Vascular

- ☐ Arteriosclerosis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pain over Heart
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Slow Heart Beat
- ☐ Swelling of Ankles
- ☐ Heart Disease

Respiration

- ☐ Asthma
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Spitting up Blood
- ☐ Spitting up Phlegm
- ☐ Wheezing
- ☐ Whooping Cough

Skin

- ☐ Boils
- ☐ Bruise Easily
- ☐ Dryness
- ☐ Eczema
- ☐ Hives or Allergies
- ☐ Skin Eruption

Genito-Urinary

- ☐ Bed Wetting
- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Inability to Control Kidneys
- ☐ Kidney Infection or Stones
- ☐ Painful Urination
- ☐ Prostate Trouble
- ☐ Pus in Urine

Eyes, Ears, Nose, & Throat

- ☐ Colds
- ☐ Crossed Eyes
- ☐ Earache
- ☐ Ear Discharge
- ☐ Eye Pain
- ☐ Failing Vision
- ☐ Far Sightedness
- ☐ Gum Trouble
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Nasal Obstruction
- ☐ Near Sightedness
- ☐ Nosebleeds
- ☐ Sinus Infection
- ☐ Sore Throat
- ☐ Tonsillitis

For Women Only

- ☐ Excessive Menstrual Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Menopausal Symptoms
- ☐ Painful Menstruation
- ☐ Miscarriage
- ☐ **Are you Pregnant?**
  - ○ Yes ○ No

IN-LINE CHIROPRACTIC CARE, P. A.
1919 NORTH LOOP WEST, STE. 180 HOUSTON, TX 77008
Office 713-699-3200 Fax 713-699-3234

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I, _____, here by authorize _____ to use and/or disclose to **In-Line Chiropractic Care** the following specific protected health information:

☐ **All Medical Record** ☐ **Radiology Reports** **DOB:** ____/____/____ **DOI:** ____/____/____

2. I understand that this is valid until ____/____/____ or until Further Notice.

3. I understand that the purpose or use of the disclosure I am granting is **proper diagnosis and accurate treatment.**

4. I expressly acknowledge that this authorization is voluntary.

5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

6. I understand that this office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

7. I understand that the authorizer may revoke this authorization in writing at any time accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not effect on disclosures occurring prior to the execution of any revocation.

8. I understand that the information used or disclosed pursuant to this authorization may be subject to being discloses again by the recipient and that this information will no longer be protected by federal privacy regulations.

9. I understand that my health care and payment for my healthcare will not affect if I do not sign this form.

10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

12. This authorization is valid as of ____/____/____, the date I have signed below.

_____ _____
Name of individual (Printed) Signature of individual

_____ _____
Signature of Legal Representative* Relationship

Witness : _____

*Attorney-In Fact, Guardian, Parent if a minor

In Line Chiropractic Care, P.A.
Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to SHARON JOUBERT-GILBERT D.C., the following rights, now power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive irrevocable right to receive payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to IN-LINE CHIROPRACTIC CARE, and to send all checks to P.O. Box 16013 Houston, TX. 77222.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a thirds party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to IN-LINE CHIROPRACTIC CARE, and to send any and all checks to P.O. Box 16013 Houston, TX 77222.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM claim in my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further my carrier to pay up to available limits directly to physician/clinic named above, and to send any and all checks or financial instruments to P.O. Box 16013 Houston, TX. 77222.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify the physician/facility immediately. I understand that failure to do so may jeopardize my case.

_____
Signature of patient/responsible parties

_____/_____/_____
Date