

Información del Paciente

Date _____ <i>Fecha</i>		Home Phone _____ <i>Tel. Casa</i>	
Name _____ <i>Nombre</i>		Soc. Sec # _____ <i>Seguro Social</i>	Work Phone _____ <i>Tel. Trabajo</i>
Address _____ <i>Dirección</i>		City _____ <i>Ciudad</i>	State _____ Zip _____ Sex M _____ F _____ <i>Estado Código postal Sexo M F</i>
Age _____ <i>Edad</i>	Birthdate _____ <i>Fecha de nacimiento</i>	Single _____ Married _____ <i>Soltero/a Casado/a</i>	Date your pain began _____ <i>Fecha del comienzo de su dolor</i>
Patient Employed by _____ <i>Paciente empleado por</i>		Occupation _____ <i>Ocupación</i>	Did it occur suddenly _____ or gradually _____ <i>Le ocurrió repentinamente o gradualmente</i>
Whom may we thank for referring _____ <i>A quien se le agradecerá por referir/a?</i>		Number of years doing current job _____ <i>Cuántos años tiene en este trabajo</i>	
In case of emergency who should be notified? _____ <i>En caso de emergencia a quien se le notificará?</i>		Relationship _____ <i>Relación</i>	Phone _____ <i>Teléfono</i>

PRESENT SYMPTOMS/ Sintomas presentes

CIRCLE WHICH APPLIES *Circule el qué aplica*

Pain <i>Dolor</i>	Stiffness <i>Tieso</i>	Tingling <i>Hormigueo</i>	Numbness <i>Entumecimiento</i>
P	S	T	N Neck <i>Cuello</i>
P	S	T	N Mid back <i>Espalda</i>
P	S	T	N Low back <i>Cintura</i>
P	S	T	N Shoulder <i>Hombro</i>
P	S	T	N Arm <i>Brazo</i>
P	S	T	N Hand <i>Mano</i>
P	S	T	N Hip <i>Cadera</i>
P	S	T	N Knee <i>Rodilla</i>
P	S	T	N Leg <i>Pierna</i>
P	S	T	N Foot <i>Pie</i>
P	S	T	N Chest <i>Pecho</i>
P	S	T	N Head <i>Cabeza</i>
P	S	T	N Eyes / ears <i>Ojos / orejas</i>
P	S	T	N Abdominal <i>Estómago</i>

ADDITIONAL SYMPTOMS *Síntomas adicionales*

- ☐ 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 *Agravados por*

- ☐ 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/weeks? ___ Dates from ___ Thru ___
A perdido tiempo en su trabajo Sí ___ No ___ Cuántos días/semanas? ___ Desde la fecha de ___ Hacia ___

Have you gone to the emergency room for this condition? Yes ☐ No ☐ Date _____ Where _____
 ¿Ha ido al cuarto de emergencia por esta condición?(estado) Sí ☐ No ☐ Fecha _____ Dónde _____

Have you been hospitalized for this condition? Yes _____ No _____ Date _____ Which hospital _____
 ¿A sido hospitalizado por esta condición (estado) Sí _____ No _____ Fecha _____ Cual hospital _____

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

Address _____
Dirección _____

City _____ State _____ Zip _____ Phone _____
Ciudad _____ Estado _____ Código Postal _____ Teléfono _____

HEALTH HISTORY/ Historia de Salud

Are you receiving care for any other conditions? Yes _____ No _____ Which condition? _____
 Esta recibiendo cuidado por alguna otra razón? Si _____ No _____ Que condición? _____

Other conditions _____
Otras condiciones _____

Are you taking medication for any conditions? Yes ☐ No ☐
 Esta tomando medicamento por alguna condición? Sí ☐ No ☐

List medications:
Lista de medicamentos:

1. _____ Condition _____
Condición

2. _____ Condition _____
Condición

3. _____ Condition _____
Condición

4. _____ Condition _____
Condición

PREVIOUS INJURIES/ Lastimaduras previas

Have you had any previous injuries that may relate to this condition? ☐ Yes ☐ No Explain _____
A tenido alguna lastimadura previa que se pueda relacionar con esta condición? ☐ Sí ☐ No Explica _____

Did you receive care for this injury? ☐ Yes ☐ No When? _____ Type of care: ☐ Chiropractic ☐ Medical ☐ Physical therapy
Recibió cuidado sobre esta lastimadura? ☐ Sí ☐ No Cuando? _____ Tipo de cuidado Quiropráctico Médico Terapia física

Have you had any previous automobile accidents? ☐ Yes ☐ No When? _____ Were you injured? ☐ Yes ☐ No
A Tenido algún accidente automovilístico previo? ☐ Sí ☐ No Cuando Fue lastimado/a? ☐ Sí ☐ No

Did you receive care after this accident? ☐ Yes ☐ No When? _____ Type of care: ☐ Chiropractic ☐ Medical ☐ Physical therapy
Recibió cuidado despues de este accidente? ☐ Sí ☐ No Cuando Tipo de cuidado Quiropráctico Médico Terapia física

Have you had any surgeries ☐ Yes ☐ No When? _____ For what condition? _____
A tenido alguna cirugía/s ☐ Sí ☐ No Cuando Sobre que condición?

Do you still have pain resulting from surgery? ☐ Yes ☐ No Describe _____
Como resultado de la cirugía todavía tiene dolor? ☐ Sí ☐ No Describa _____

HEALTH INSURANCE INFORMATION/ Información sobre la aseguranza

Company's name _____ Phone _____
Nombre de la compañía Teléfono

Address _____ City _____ State _____ Zip _____
Dirección Ciudad Estado Código postal

Insured (If other than yourself) _____ Relationship _____
Asegurado (Otra persona aparte de usted) Relación

Address _____ Phone _____
Dirección Teléfono

Adjuster _____ Claim # _____ Policy # _____
Agente Número de demanda Número de póliza

ADDITIONAL INSURANCE INFORMATION/ Información adicional sobre la aseguranza

If you are covered under more than one group health policy, please supply the appropriate information.
Si usted tiene mas de una póliza que le cubra, favor de proveer la información adecuada.

Company's name _____ Phone _____
Nombre de la compañía Teléfono

Address _____ City _____ State _____ Zip _____
Dirección Ciudad Estado Código postal

Insured (If other than yourself) _____ Relationship _____
Asegurado (Otra persona aparte de usted) Relación

Address _____ Phone _____
Dirección Teléfono

Adjuster _____ Claim # _____ Policy # _____
Agente Número de demanda Número de póliza

Please have your insurance card available, so that we can make a copy for our records.
Por favor tenga su tarjeta de aseguranza lista, para que nosotros podamos hacer una copia para nuestros archivos.

ASSIGNMENT OF BENEFITS/ Asignación de beneficios

I authorize payment of the benefits relating to this claim to be paid directly to:
Yo autorizo el pago de los beneficios relacionados a esta demanda para que sea pagada directamente a:

[]

Patient's Signature _____
Firma del paciente

Date _____
Fecha

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
Yo entiendo claramente y estoy de acuerdo que todos los servicios que se hagan sean cobrados a mi, yo personalmente me hago responsable por el pago. También entiendo que si paro o suspendo mi tratamiento y cuidado, de los servicios profesionales hacia mi persona serán inmediatamente pagados.

Patient's Signature _____
Firma del paciente

Date _____
Fecha

CONSULTATION

Consulta

Name
Nombre

Date
Fecha

ONSET/ Empezar

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

☐ Same day of the accident/injury El día del accidente/lastimadura
☐ The next day El día siguiente

☐ Two or three days later Dos o tres días después

Have you had any previous accidents? ☐ Yes ☐ No When?
A tenido algún accidente anteriormente? Sí No Cuando?

Have you ever had the same/similar symptoms? ☐ Yes ☐ No
A tenido el mismo síntoma anteriormente? Sí No

PROVOKE/QUALITY/ Calidad

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

☐ Bending Agacharse ☐ Sitting Sentarse ☐ Walking Caminando
☐ Standing Pararse ☐ Lifting Levantando ☐ Driving Manejando

Are you sleeping comfortably? ☐ Yes ☐ No Why not?
Esta dormiendo cómodo/a? Sí No Porque no?

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

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

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

Are you taking medication for pain? ☐ Yes ☐ No
Esta tomando medicamento para el dolor? Sí No

RADIATING/ Radiando

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

Arm/s Brazo ☐ Right Derecho ☐ Left Izquierdo ☐ Both Ambos
Leg/s Pierna ☐ Right Derecha ☐ Left Izquierda ☐ Both Ambas

SITE/ Localidad

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

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

TIMING/ Frecuencia

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

How frequent is your pain? ☐ Constant ☐ Intermittent
Que tan frecuente es su dolor? Constante Intermitente

PREVIOUS CARE/ Cuidado previo

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

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

☐ DC Quiropráctico ☐ MD Medico ☐ DO Osteopata

☐ Therapist Where were you seen?
Terapeuta Donde fue usted visto?

What was done? Que le hicieron?

☐ X-rays Radiografías ☐ Medication Medicamento prescrito
☐ Examination Examen ☐ Treatment Tratamiento

WORK STATUS/ Trabajo

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

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

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

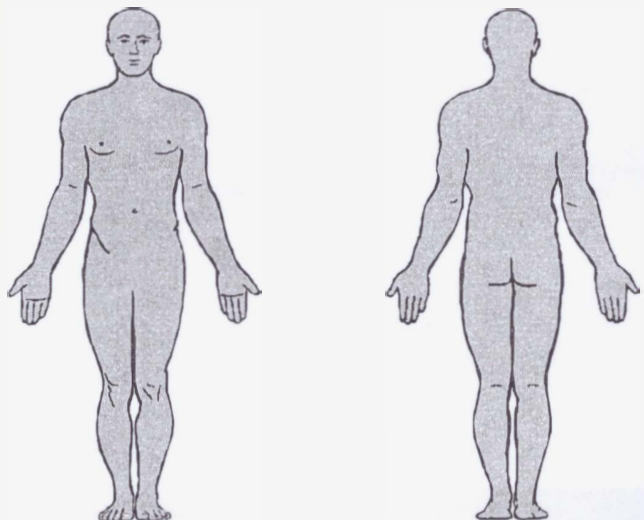
DISABILITY/ Incapacidad

Are you currently on disability? ☐ Yes ☐ No
Esta actualmente incapacitado? Sí 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? Sí 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
☐ Falling 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