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 ___ Birthdate *Edad 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*	Numbness *Entumecimiento*	
☐ P	☐ S	☐ T	☐ N	Neck *Cuello*
☐ P	☐ S	☐ T	☐ N	Mid back *Espalda*
☐ P	☐ S	☐ T	☐ N	Low back *Cintura*
☐ P	☐ S	☐ T	☐ N	Shoulder *Hombro*
☐ P	☐ S	☐ T	☐ N	Arm *Brazo*
☐ P	☐ S	☐ T	☐ N	Hand *Mano*
☐ P	☐ S	☐ T	☐ N	Hip *Cadera*
☐ P	☐ S	☐ T	☐ N	Knee *Rodi/la*
☐ P	☐ S	☐ T	☐ N	Leg *Pierna*
☐ P	☐ S	☐ T	☐ N	Foot *Pie*
☐ P	☐ S	☐ T	☐ N	Chest *Pecha*
☐ P	☐ S	☐ T	☐ N	Head *Cabeza*
☐ P	☐ S	☐ T	☐ N	Eyes / ears *Ojos I orejas*
☐ P	☐ S	☐ T	☐ N	Abdominal *Est6mago*

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 ◯ *A perdido tiempo en su trabajo Si No* How many days lost? *Cuantos días ha perdido* ___ Dates from *Desde la fecha de* _____ Thru *Hacia* _____

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

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

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

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

PAYMENT INFORMATION/ *Información del pago*

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for
Yo enfiendo claramente y estoy de acLJerdo qLJe todos los fervicios que se me hagan sean cobrados a mi; yo personalmente me hago responsab/e

payment. I also understand that if I suspend or ter inate my care and treatment any fees for professional services rendered me will
por el pago. Tamb1en entendo qLJe si paro o suspendo mi tratamiento y cuidado de los servicios profesionales hacia mi persona seran mmediata
be immediately due and payable.
mente pagados.

Patient's Signature _____ Date _____

Firina def paciente _____ Fecl1a _____

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

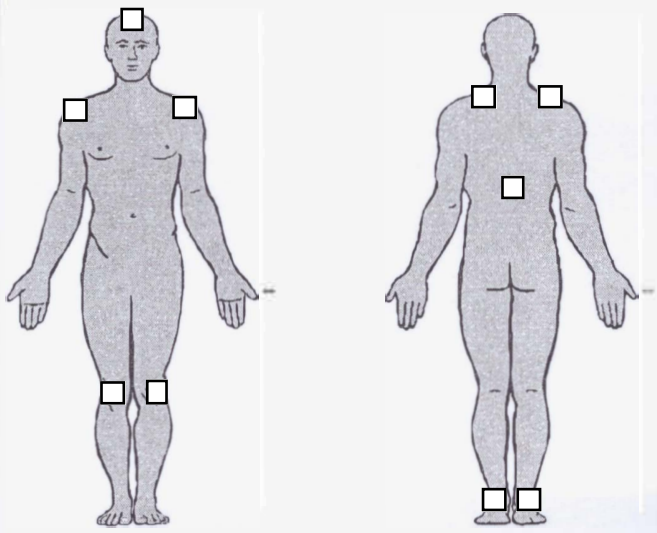
DISABILITY/ Incapacidad

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