21st Century Chiropractic and Rehab

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"Health Care For The New Millennium"

WELCOME TO OUR CLINIC

Please take a moment to complete the following paperwork so that we may assist you with your health care needs. Thank you.

PATIENT INFORMATION

Date _____ Social Security # _____ Age ___ Date of Birth _____

Name (Last, First, Middle) _____ Mobile # _____

Street Address _____ City _____

State ____ Zip Code _____ Home # _____ Email _____

Male ___ Female ___ Minor ___ Married ___ Single ___ Divorced ___ Widowed ___ Separated ___

Employer _____ Occupation _____ Work Phone _____

Emergency Contact _____ Phone _____

How did you find us? Referral from a patient _____ Other _____

REASON FOR VISIT

Please tell us why you are here and any current health problems or symptoms: Auto □ Work □ Other □

_____

_____

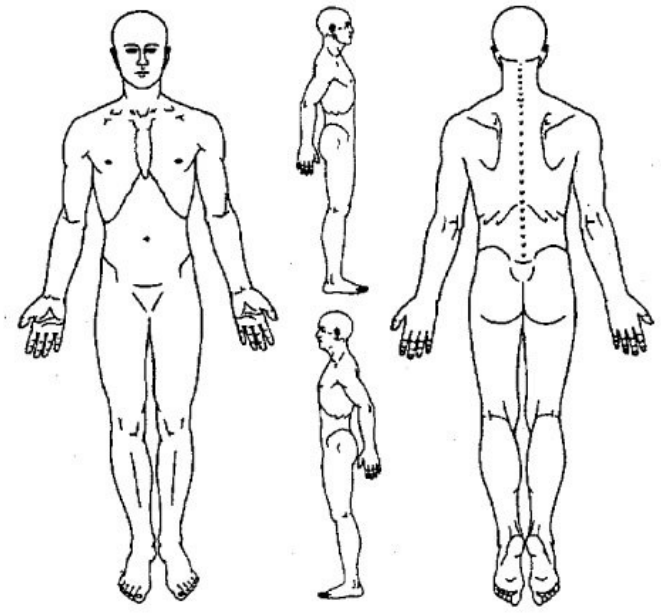
_____

_____

_____

REASON FOR VISIT AND CHIEF COMPLAINT

On the diagram below, please draw a circle around the area(s) of your body that hurt (for example, the neck, mid back, low back, right knee, etc.) and mark all that apply. Now tell us about the condition, does it hurt all day long? Once a week, etc.? And then describe the quality of the pain (mild, moderate, stiff, achy, dull, etc.) and mark all that apply.



THE CONDITION IS:	**EL PROBLEMA ES:**
Constant (All day)	**Constante**
Intermittent (several times/day)	**Intermedio**
Occasional (once a week or less)	**Ocacional**
Mild	**Medio**
Moderate	**Moderado**
Severe	**Severo**
Extreme	**Extremo**
Tight/Stiff	**Apretado/Tension**
Achy	**Dolor Continuo**
Dull	**Dolor Menor**
Sharp/Stabbing	**Filado**
Burning	**Quemando**
Numb	**Dormido**
Tingling	**Hormigeo**
Other: _____	**Otro: _____**

Now tell us how the pain effects your ability to go about your daily activities, just put a slash on the line below to show how the pain impacts your life.

0		**5**		**10**
No Pain No Dolor	**Can do most things despite the pain**	**Hurts all the time doing most things**	**Pain prevents most things**	**Terrible pain, worst ever. Terrible dolor**

Is your condition getting: Better: □ Worse: □ Staying the same: □

Patient's Signature: _____ **Date:** _____
Firma del Paciente: _____ **Fecha:** _____

21st Century Chiropractic & Rehab Web: PhysicalMedicine.com Phone: 214-366-1133 Fax: 214-366-3916
East Dallas: 2114 Kidwell Street, Dallas, TX 75214 Northwest Dallas: 2739 Bachman Drive, Dallas, TX 75220

MEDICAL HISTORY

What treatment have you already received for your current condition? Surgery □ Physical Therapy □

Chiropractic □ Heat □ Ice □ Medications □ _____

None □ Other _____

1. Are you currently under medical treatment for this or any other condition? No ____ Yes ____

Please describe _____

2. Have you had any serious illnesses or operations? No ____ Yes ____

Please describe _____

3. Are you currently taking any medications? No ____ Yes ____

Medication _____ Purpose _____

Medication _____ Purpose _____

Medication _____ Purpose _____

Medication _____ Purpose _____

4. Do you smoke? No ____ Yes ____ How much? _____

5. Do you use alcohol? No ____ Yes ____ How much? _____

6. Do you drink water? No ____ Yes ____ How much? _____

7. Do you use any street drugs? No ____ Yes ____ How much? _____

MEDICAL HISTORY

Please mark the boxes below under the headings: "Yes □ " "No □ " "Current □ " to indicate if you have **had this condition in the past,** have **never had** this condition, or are **currently experiencing** this condition.

Aids/HIV	□ yes	□ no	□ current
Alcoholism	□ yes	□ no	□ current
Allergies	□ yes	□ no	□ current
Anemia	□ yes	□ no	□ current
Anorexia	□ yes	□ no	□ current
Arthritis	□ yes	□ no	□ current
Asthma	□ yes	□ no	□ current
Bleeding Disorders	□ yes	□ no	□ current
Breast Lump	□ yes	□ no	□ current
Bronchitis	□ yes	□ no	□ current
Bulimia	□ yes	□ no	□ current
Cancer	□ yes	□ no	□ current
Cataracts	□ yes	□ no	□ current
Chemical Dependency	□ yes	□ no	□ current
Chicken pox	□ yes	□ no	□ current
Diabetes	□ yes	□ no	□ current
Emphysema	□ yes	□ no	□ current
Epilepsy	□ yes	□ no	□ current
Fractures	□ yes	□ no	□ current
Glaucoma	□ yes	□ no	□ current
Goiter/Thyroid	□ yes	□ no	□ current
Gonorrhea	□ yes	□ no	□ current
Gout	□ yes	□ no	□ current
Heart Disease	□ yes	□ no	□ current
Hepatitis	□ yes	□ no	□ current
Hernia	□ yes	□ no	□ current
Herpes	□ yes	□ no	□ current
High Cholesterol	□ yes	□ no	□ current
High Blood Press.	□ yes	□ no	□ current
Kidney Disease	□ yes	□ no	□ current
Liver Disease	□ yes	□ no	□ current
Measles	□ yes	□ no	□ current
Migraine	□ yes	□ no	□ current
Miscarriage	□ yes	□ no	□ current
Mononucleosis	□ yes	□ no	□ current
MS	□ yes	□ no	□ current
Mumps	□ yes	□ no	□ current
Osteoporosis	□ yes	□ no	□ current
Pacemaker	□ yes	□ no	□ current
Parkinson's	□ yes	□ no	□ current
Pinched Nerve	□ yes	□ no	□ current
Pneumonia	□ yes	□ no	□ current
Polio	□ yes	□ no	□ current
Prostate	□ yes	□ no	□ current
Psychiatric Care	□ yes	□ no	□ current
Rheumatoid Arthritis	□ yes	□ no	□ current
Rheumatic Fever	□ yes	□ no	□ current
Scarlet Fever	□ yes	□ no	□ current
Stroke	□ yes	□ no	□ current
Tuberculosis	□ yes	□ no	□ current
Tumors	□ yes	□ no	□ current
Typhoid Fever	□ yes	□ no	□ current
Ulcers	□ yes	□ no	□ current
Vaginal Infections	□ yes	□ no	□ current
Venereal Disease	□ yes	□ no	□ current
Whooping Cough	□ yes	□ no	□ current

Other _____

_____

_____

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INFORMED CONSENT • PERMISSION TO TREAT • HIPAA

I _____, by signing this form below, am requesting and consenting that the following routine evaluation, diagnostic and therapeutic procedures be performed upon myself (or the minor designated below), by 21st Century Chiropractic, its doctors and staff.

Please initial after discussing with the attending doctor.

____ Chiropractic/Medical Evaluation

____ Conventional Radiographs/X-Rays

____ Chiropractic Treatment/CMT

____ Physical Medicine Treatment

____ Physical Rehabilitation Program

____ Other _____

_____

_____ _____

Patient or Parent/Guardian's Signature

I have been informed of the following:

1. The nature and purpose of the treatment.
2. Alternative treatment options and/or options.
3. Projected duration of treatment.
4. Common side effects from the treatment prescribed.
5. My questions have been answered to my satisfaction.

I fully understand that I may at any time refuse treatment and withdraw my consent for the performance of any procedure or treatment. Should I revoke this consent, I will be requested to sign a form of acknowledgment.

I am aware that the science of Chiropractic/Medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees have been, or can be made regarding the likelihood of success or the outcome of any evaluations, treatment, test, procedure, or therapy performed by 21st Century Chiropractic, its doctors and staff.

I have read and understand to my satisfaction all of the above and certify that I have had the opportunity to discuss the contents with my attending doctor.

Authorization of Patient/Guardian:

_____ _____

Patient's Signature or Parent/Guardian's Signature Date

_____ _____

Parent or Guardian's Signature Relationship to Minor Date

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