Willow Bend Chiropractic

5930 W. Park Blvd. * Suite 500 * Plano, Texas 75093 * (972) 267-5998

Patient Information

Date_______________

Name ____

First M. Last Preferred Name

Address ______________________________________

____

City State Zip

Sex: ☐ M ☐ F Birthdate ___/___/___ Age______

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # ______________________________

Occupation ________________________________

Employer __________________________________

Employer Address ___________________________

____

City State Zip

Spouse ____________________________________

Occupation _________________________________

Whom may we thank for referring you?

____

____

Contact Information

Home Phone_________________________________

Work Phone ______________________ Ext. ________

Other Phone ________________________________

E-mail _____________________________________

IN CASE OF AN EMERGENCY, CONTACT:

Name ______________________________________

Phone ______________________________________

Insurance Information

Insured's Name _______________________________

Insured's Birthdate ___/___/___

Relationship to Patient:

☐ Same Person ☐ Spouse ☐ Parent ☐ Other

Insurance Company___________________________

I.D./Policy # ________________ Group # ___________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above listed insurance company and assign directly to Willow Bend Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

____

Relationship to Patient Date

Accident Information

If Condition Due to an Accident

Accident Date ________________________________

Type Of Accident: ☐ Auto ☐ Work ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker's Comp ☐ Other

Attorney Name (if applicable)____________________

Attorney Phone ______________________________

Patient Condition

Height __________ Weight __________

Reason for visit ______________________________________

When did your symptoms appear? ________________________

Is this condition getting progressively worse?

☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 to 10

0---------------------------5---------------------------10

(no pain) (severe pain)

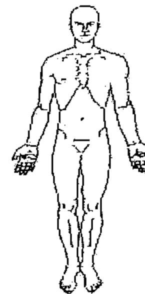
Type of Pain:

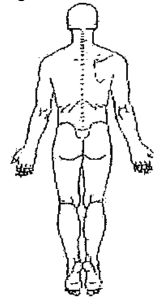
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness

☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramping ☐ Stiffness ☐ Swelling ☐ Other

Mark an X on the picture where you continue to have pain, numbness, or tingling





How often do you have this pain (is it constant or does it come and go)? ______________________________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Additional Comments Concerning Your Condition:

____

____

____

____

Health History

What treatment have you already received for your condition? ☐ Chiropractic Services ☐ Medications ☐ Surgery
☐ Physical Therapy ☐ None ☐ Other ______________________________

Name and telephone number of other doctor(s) who have treated you for your condition ______________________________

Date of Last: ☐ Chiropractic Adjustment _________ ☐ Medical Appointment _________ ☐ Massage _________

Place a mark on "past", "present", or "never" to indicate if you have had any of the following:

Past	Present	Never	Condition
☐	☐	☐	AIDS/HIV
☐	☐	☐	Abnormal Weight Gain
☐	☐	☐	Allergy Shots
☐	☐	☐	Anemia
☐	☐	☐	Angina
☐	☐	☐	Anorexia
☐	☐	☐	Appendicitis
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Bleeding Disorders
☐	☐	☐	Breast Lump
☐	☐	☐	Bronchitis
☐	☐	☐	Bulimia
☐	☐	☐	Cancer
☐	☐	☐	Chest Pains
☐	☐	☐	Constipation or Diarrhea
☐	☐	☐	Diabetes
☐	☐	☐	Dizziness
☐	☐	☐	Emphysema
☐	☐	☐	Epilepsy
☐	☐	☐	Excessive Thirst
☐	☐	☐	Fractures
☐	☐	☐	General Fatigue

Past	Present	Never	Condition
☐	☐	☐	Glaucoma
☐	☐	☐	Gout
☐	☐	☐	Heart Disease
☐	☐	☐	Hepatitis
☐	☐	☐	Hernia
☐	☐	☐	Herniated Disc
☐	☐	☐	High Blood Pressure
☐	☐	☐	High Cholesterol
☐	☐	☐	Kidney Disease
☐	☐	☐	Lazy Eye
☐	☐	☐	Liver Disease
☐	☐	☐	Loss of Bladder Function
☐	☐	☐	Migraine Headaches
☐	☐	☐	Mononucleosis
☐	☐	☐	Multiple Sclerosis
☐	☐	☐	Muscle Spasms
☐	☐	☐	Muscular Incoordination
☐	☐	☐	Osteoporosis
☐	☐	☐	Pacemaker
☐	☐	☐	Painful/Frequent Urination
☐	☐	☐	Parkinson's Disease
☐	☐	☐	Pinched Nerve
☐	☐	☐	Pneumonia

Past	Present	Never	Condition
☐	☐	☐	Polio
☐	☐	☐	Poor Circulation
☐	☐	☐	Prostate Problems
☐	☐	☐	Prosthesis
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Ringing in Ears
☐	☐	☐	Sensitivity to Light
☐	☐	☐	Stroke
☐	☐	☐	Thyroid Problems
☐	☐	☐	Tuberculosis
☐	☐	☐	Tumors/Growths
☐	☐	☐	Ulcers
☐	☐	☐	Visual Disturbance

Females Only

Past	Present	Never	Condition
☐	☐	☐	Birth Control
☐	☐	☐	Painful Periods
☐	☐	☐	Hormonal Replacement
☐	☐	☐	Currently Pregnant
☐	☐	☐	Trying to Become Pregnant
☐	☐	☐	Miscarriage

Please List All Surgeries and Major Injuries (fractures, motor vehicle accidents, etc.):

____

____

Medications

____

Allergies

____

Vitamins

____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

LIFESTYLE

☐ Smoking — Packs/Day__________
☐ Alcohol — Drinks/Day__________
☐ Coffee/Caffeine — Cups/Day__________
☐ Water — Glasses/Day__________

Consent to Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures. This includes examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible), which are recommended by the doctor of Chiropractic who now, or in the future, renders treatment to me, while employed by, working for, associated with, or serving as backup for the doctor of Willow Bend Chiropractic.

I have had an opportunity to discuss with the doctor and or with office personnel the nature, purpose and risks of Chiropractic adjustments and their recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed

I have read the above explanation of the Chiropractic adjustment and related treatment. By signing below I stat that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having had the opportunity to ask about the risks, I hereby give my consent to that treatment. 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 Name | Patient/Legal Guardian Signature | Date