WOODLANDS FAMILY CHIROPRACTIC
128 Vision Park Blvd, Suite 250
The Woodlands, Texas, 77384
Ph 936.447.9484
Fx 936.447.9497

Patient Name: _____

Date Of Birth: _____

Date Of Exam: _____

We appreciate you choosing our office. Is there anyone we can thank for referring you?

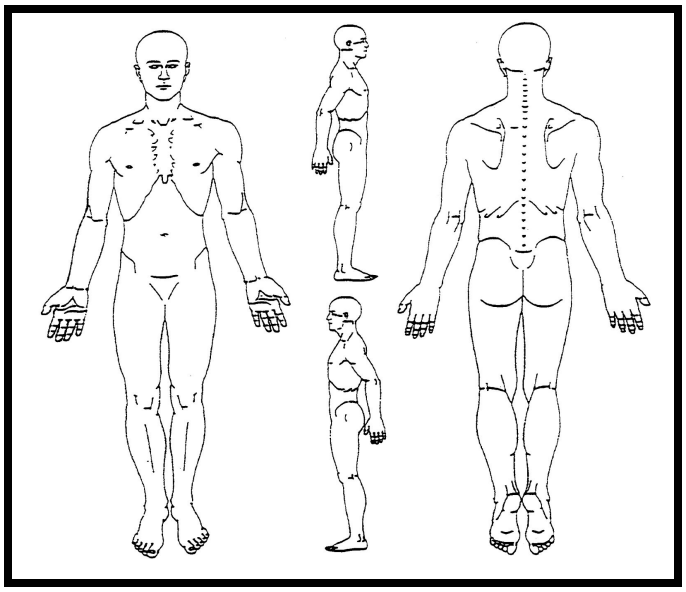
_____

Please indicate the main reason you are seeing us today:

_____

IF you are seeing us for a PAIN related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	SHARP/STABBING	NUMBNESS/TINGLING	STIFF/TIGHT	BURNING



Using the PAIN SCALE below, CIRCLE the pain level you experience when your problem is at its WORST:

0 = **No Pain**. No Discomfort
1 = **Minimal Discomfort**. Minor stiffness or tightness.
2 = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
3 = **Minimal Pain**. More than just sore. Uncomfortable.
4 = **Mild Pain**. Noticeable pain but tolerable.
5 = **Moderate Pain**. Aggravating. Still allows movement.
6 = **Strong Pain**. Quite aggravating. Movement slightly limited.
7 = **Very Strong Pain**. Very aggravating. Movement definitely limited.
8 = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
9 = **Severe Pain**. Brings tears. Almost impossible to move.
10 = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Is there any RADIATING PAIN into the arms or legs? _____ Any numbness or tingling?

_____

How OFTEN do you experience your problem? (Please indicate for EACH SEPARATE LOCATION if applicable)

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Constant (75 – 100% of the time)

_____

Frequent (50 – 75% of the time)

_____

Occasional (25 – 50% of the time)

_____

Intermittent (0 – 25% of the time)

_____

List any MD's or other CHIORPRACTORS you've already seen for this problem:

_____

What TESTS have you already had for this problem? •X-rays •MRI •C.T. Scan •Myelogram •EMG/NCV •None •Other

_____

_____

What REMEDIES have you already tried for this problem that haven't fixed it yet? •Anti-inflammatory •Pain Meds •Muscle Relaxers •Injections •Physical Therapy •Chiropractic •Massage •Exercise •Other

_____

What makes your problem WORSE? •Sitting •Standing •Changing Position •Walking •Bending •Lifting •Twisting •Reaching •Driving •Sleeping •Sneeze/Cough •Computer Work •Telephone •Going From Sit To Stand •Other_____

_____

PAST MEDICAL HISTORY

Please list any conditions that you've been DIAGNOSED with or been treated for over the course of your life:

_____

_____

_____

_____

Please list any SURGERIES you have had over the course of your life:

_____

_____

_____

MEDICATIONS & ALLERGIES

Are you ALLERGIC to any medications? •Yes •No **If yes, please list:**

_____

List any MEDS, HERBS OR SUPPLEMENTS you are taking:

_____

_____

_____

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FAMILY HISTORY

Mother: •Living •Deceased List any medical problems:

_____

Father: •Living •Deceased List any medical problems:

_____

List any problems COMMON in your family: •Cancer •Diabetes •Heart disease •High blood pressure •Stroke •Arthritis •Scoliosis •Thyroid disease •Osteoporosis

_____

SOCIAL HISTORY

Marital status: •Married •Single •Divorced •Common Law •Engaged •Widowed

Do you have any children? •Yes •No If yes, how many?

_____

Do you drink alcohol? •Yes •No If yes, how much & how often?

_____

Do you smoke? •Yes •No If yes, how much, how often & how long?

_____

Do you use any illegal drugs? •Yes •No If yes, what drugs, how often & how long?

_____

Are you currently employed? •Yes •No If yes, what is your occupation?

_____

Who is your current employer? _____ **How long have you been at this job?**

_____

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____ = _____

Do you take: Omega 3 (Fish Oil)? Yes No Vitamin D3? Yes No Probiotics? Yes No

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head:	**Energy/Activity:**	**Lungs:**
_____ Headaches	_____ Fatigue/Sluggishness	_____ Chest Congestion
_____ Faintness	_____ Apapthy/Lethargy	_____ Asthma, Bronchitis
_____ Dizziness	_____ Hyperactivity	_____ Shortness Of Breath
_____ Insomnia	_____ Restlessness	_____ Difficulty Breathing

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Eyes: _____ Watery or Itchy Eyes _____ Swollen, Red or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (not including near or far sightedness)	**Weight:** _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight	**Heart:** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain
Ears: _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage From Ear _____ Ringing In Ears, Hearing Loss	**Emotions:** _____ Mood Swings _____ Anxiety/Fear/Nervousness _____ Anger/Irritability/Aggressiveness _____ Depression	**Digestive Tract:** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal/Stomach Pain
Nose: _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation	**Mind:** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty Making Decisions _____ Stuttering or Stammering _____ Slurred speech	
Mouth & Throat: _____ Chronic Coughing _____ Frequent Need to Clear Throat _____ Sore Throat, Hoarseness _____ Swollen or Discolored Tongue _____ Canker Sores		**Other:** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge
Skin: _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating	**Joints/Muscles:** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Weakness or Fatigued Muscles	**Grand Total:**

ASSIGNMENT OF BENEFITS & RELEASE OF HEALTHCARE INFORMATION

I hereby authorize Keyes to Health, PLLC (KTH) doing business as Woodlands Family Chiropractic (WFC) to release patient healthcare information, compiled from the medical record pertaining to my services, in accordance with the policy of the clinic and Texas law, to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to my insurance carries, Medicare or any other payor or agency. I also hereby authorize for services rendered. I am financially responsible and will pay for charges not covered on my insurance plan.

Initial: _____

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CONSENT TO TREATMENT

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving chiropractic services, which may include routine diagnostic procedures and treatment by the chiropractor, his assistants or designees, considered to be necessary in his judgment. I also acknowledge that the practice of health care is not an exact science and that no guarantees have been made to me as to results of treatment or examination at KTH/WFC.

Initial: _____

FINANCIAL AGREEMENT & RESPONSIBILITY

For and in consideration of services rendered or to be rendered by KTH/WFC**,** I agree to pay clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. Payment in full is due at the time services are rendered or payment arrangements are to be made before your appointment.

Initial: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE--HIPPA

I, the undersigned, hereby acknowledge receipt of the Notice of Privacy Practices for this practice. I understand how my healthcare information will be used and disclosed.

Patient/Guarantor Signature: _____ Date: _____