**Liberty Chiropractic Clinic**
**12325 Scarsdale Blvd., Houston, TX 77089-6154**

Date ________________________

Patient's Name ____________________________________________

Patient's Address ______________________City ________________ State _______ Zip Code _________

Age ________ D.O.B. _______________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed No. of children ____

Occupation ______________________________ Employer ______________________________

Home Phone ____________________ Work Phone _________________________ Cell Phone ___________________

Email Address ____________________________________________

Are you insured? ☐ Yes ☐ No Name of Insurance Co. ______________________________

Please list your family physician. May we have your permission to contact them? ☐ Yes ☐ No

____________________________________________

Emergency Contact _______________________ Relationship _________________ Contact Phone ________________

Who referred you? ____________________________________ Date of last physical exam _______________________

**What is the reason for today's appointment?**

Primary condition: ____________________________________________

Condition 1: ____________________________________________

Condition 2: ____________________________________________

Are all the above condition(s) due to an Auto Accident? ☐ Yes ☐ No or Work Related Injury? ☐ Yes ☐ No

Condition(s) began when and how? ______________________________

What is the Quality of the complaints/pain? ☐ dull ☐ aching ☐ sharp ☐ shooting ☐ burning ☐ throbbing
☐ deep ☐ nagging Other ______________________________

Does this condition/pain radiate or travel (shoot) to any other areas of your body? ☐ Yes ☐ No Where? _________

Do you have numbness or tingling in your body? ☐ Yes ☐ No Where? ______________________________

Grade Intensity/Severity ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

(Where "0" is No complaint/pain and where "10" is the Worst pain/complaint imaginable)

How frequent are condition(s) present, how long does it last? ______________________________

Does anything aggravate the condition(s)? ☐ Yes ☐ No Describe ______________________________

Does anything make the condition(s) better? ☐ Yes ☐ No Describe ______________________________

Describe interventions, treatments, medications, surgery or care that you've sought for your condition:

____________________________________________

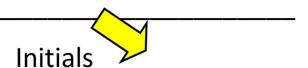
**Past Health History**

Previous Illnesses: ____________________________________________

Previous Injury/trauma: ____________________________________________

Broken bones? Which? ____________________________________________

Allergies: ____________________________________________

Initials  __________

Medications: Reason for taking this medicine

1. ______________________________ ______________________________

2. ______________________________ ______________________________

Surgeries: Type of surgery

1. ______________________________ ______________________________

2. ______________________________ ______________________________

**Females** What was the date of your last menstrual period? ______________ Are you pregnant now? ☐ Yes ☐ No

**Lifestyle**

How often do you exercise? ☐ Daily ☐ Weekly ☐ Sometimes ☐ Never

How often do you drink alcohol? ☐ Daily ☐ Weekly ☐ Sometimes ☐ Never

How often do you smoke? ☐ Daily ☐ Weekly ☐ Sometimes ☐ Never

Do you use recreational drugs? ☐ Daily ☐ Weekly ☐ Sometimes ☐ Never

How is your diet? ☐ Healthy ☐ Healthy Sometimes ☐ Fast Food

**Auto Accident?**

My Auto Insurance Co. ______________________________ Claim # ____________________

Adjuster's Name ______________________________ Adjuster's Phone # ____________________

Date of Injury ____________ Time of Day ____________ Location ______________________________

Please describe the accident ______________________________________________________

Is there any other Insurance Co involved? ☐ Yes ☐ No Do you have an attorney? ☐ Yes ☐ No

Insurance Co. Name ______________________ Attorney's Name ______________________

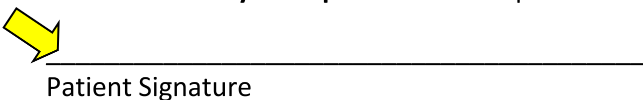
Phone # ______________________ Phone # ______________________

**PAYMENT IS EXPECTED AT THE TIME OF SERVICE**

**Person responsible for payment** ______________________________________________

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. I authorize **Liberty Chiropractic Clinic** to prepare and send any reports and forms necessary for collection of any payments from my Insurance Company or Attorney. I authorize payments to be made directly to **Liberty Chiropractic Clinic**. If I change Insurance Companies or Attorneys during my treatment I am obligated to inform **Liberty Chiropractic Clinic** immediately. I am aware that I am ultimately responsible for any and all balances due.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize **Liberty Chiropractic Clinic** to provide me with chiropractic care, in accordance with this state's statutes.



______________________________ ______________________

Patient Signature Date

______________________________ ______________________

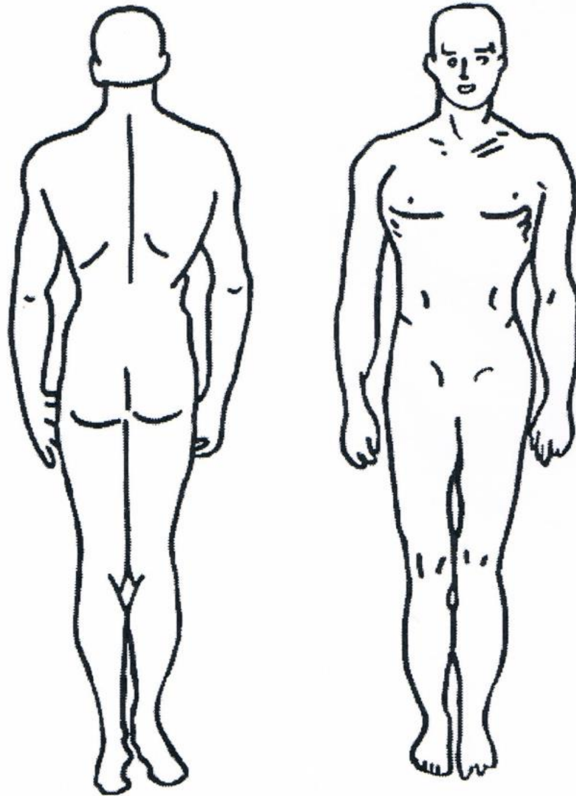
Guardian Authorizing Care Date

## Please Fill In Below

**If you have had the following, or if you suffer from the following, Please Check below...**

| Condition, Symptom or Problem | Constantly or Frequently | Sometimes or Occasionally |
|---|---|---|
| Headache | ☐ | ☐ |
| Migraines | ☐ | ☐ |
| Neck Pain | ☐ | ☐ |
| Shoulder Pain | ☐ | ☐ |
| Arm/Hand Pain | ☐ | ☐ |
| Mid Back Pain | ☐ | ☐ |
| Low Back Pain | ☐ | ☐ |
| Hip Pain | ☐ | ☐ |
| Leg/Foot Pain | ☐ | ☐ |
| Disc Problems | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Other Joint Pain | ☐ | ☐ |
| Numbness | ☐ | ☐ |
| Joint Swelling | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Nausea | ☐ | ☐ |
| Weakness | ☐ | ☐ |
| Fatigue | ☐ | ☐ |
| Nervousness | ☐ | ☐ |
| Insomnia | ☐ | ☐ |
| Heart Problems | ☐ | ☐ |
| Frequent Colds | ☐ | ☐ |
| Nose Bleeds | ☐ | ☐ |
| Ringing in Ears | ☐ | ☐ |
| Earaches | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Cough | ☐ | ☐ |
| Chest Pains | ☐ | ☐ |
| Female Problems | ☐ | ☐ |
| Allergies | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hypoglycemia | ☐ | ☐ |
| Digestive Problem | ☐ | ☐ |
| Urinary Problems | ☐ | ☐ |
| Skin Conditions | ☐ | ☐ |

**Circle the areas where you have any problems.**
**Please describe these problems.**



**Please fill in below, any other health information you feel that we might need for your wellbeing and care.**

*Thank you for being complete and thorough.*

**Please sign below**

Today's Date

## LIBERTY CHIROPRACTIC CLINIC

12325 Scarsdale Blvd.
Houston, TX 77089

### Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-ray(s), physical therapy techniques, on me (or on the named patient below for which I am legally responsible) which are recommended by John Doyle, D.C. and or any other licensed doctors or chiropractic who now or in the future render treatment to me while employed by, associated with or observing as a back up for **Liberty Chiropractic Clinic**.

I understand that, as with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to, fractures, dislocations, muscle strain, costovertebral strains and separations. Some type of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in one to three million chance). I understand that **Liberty Chiropractic Clinic** screens patients for indications that they are candidates for chiropractic manipulation to the best of their ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) which the doctor feels at the time, based on all the facts then known, are in my best interest.

I have had an opportunity to discuss with John Doyle, D.C. and/or with office personnel the nature, purpose and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state 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 been informed of 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 condition(s) for which I seek treatment.

____________________________________
Print name of patient

Signature of patient — Date

Signature of patient's **representative** — Date
(if patient is a minor)

## LIBERTY CHIROPRACTIC CLINIC

12325 Scarsdale Blvd.
Houston, TX 77089

### Assignment of Benefits

**Patient Information**

Name: Last ____________________________ First ___________________________ Middle Initial ___________

Address _____________________________________________________________________________________

City, State __________________________________________________ Zip Code ________________________

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (If other, please describe below.)

Other Relationship _____________________________________________________________________________

**Subscriber Information**

Name: Last ____________________________ First ___________________________ Middle Initial ___________

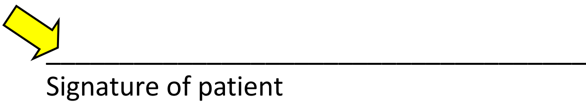
Health Plan Provider _____________________________________________________________________________

Subscriber ID # ______________________________ Group ID# ________________________________

**Patient Declaration**

I hereby authorize and direct payments to:

John Doyle, D.C.
Liberty Chiropractic Clinic
12325 Scarsdale Blvd.
Houston, TX 77089



Signature of patient

__________________________________
Date

## LIBERTY CHIROPRACTIC CLINIC

12325 Scarsdale Blvd.
Houston, TX 77089

### Patient Consent for Purpose of Treatment, Payment and Health Care Operations

I acknowledge that **Liberty Chiropractic Clinic**'s *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* described the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Liberty Chiropractic Clinic**. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this document and the right to request restrictions as to how my health information may be used.

I understand that I may revoke this consent in writing, except in the instance **Liberty Chiropractic Clinic** has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, **Liberty Chiropractic Clinic** may refuse to treat me. I understand that **Liberty Chiropractic Clinic** reserves the right to change its *Notice of Privacy Practices*. I may obtain a revised *Notice of Privacy Practices* by mail or in person.
Patient Name (Please print) _______________________________ Date of Birth ______________________

Representatives Authorized to Act for Patient ___________________________________________________

Patient Signature _______________________________________ Date _____________________________

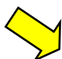
### Specific Health Care Authorization

The patient identified below authorizes **Liberty Chiropractic Clinic** to use and or disclose and *Protected Health Information* in accordance with the following:

1) I give **Liberty Chiropractic Clinic** to use my address, phone number, e-mail and clinical records to contact me with holiday cards, cards of other occasions and health related information.
2) I give **Liberty Chiropractic Clinic** to treat me in an open room. Should I need to speak with the doctor in private, the doctor will provide this.

You have the right to revoke this authorization in writing, at any time. However, your request to revoke this authorization is not effective to the extent that we have provided services or take action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written to the Privacy officer of **Liberty Chiropractic Clinic**. The written notice must contain your Name, date of birth, a clear statement of your intent to revoke this authorization, the date of your request and your signature. This revocation is not effective until it is received by the Privacy officer.

This authorization is requested by **Liberty Chiropractic Clinic** for its own use and disclosure of *Protected Health Information*.



________________________________________ ________________________________

Signature of patient Date