WELCOME

We are pleased to welcome you to our practice. Please take your time in filling out the forms as completely as you can.

Name: _____ (Age) _____ Gender: M F Date: _____

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:_____

Is this purpose related to an auto accident / work injury? □ Yes □ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? □ Yes □ No Describe:_____

Type of Pain: Aching Burning Dull Pulling Sharp Shooting Stabbing Stinging Throbbing Numb/Tingling None

Does the Pain Radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? □ Yes □ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? □ Yes □ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No

Did you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No

Explain: The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

Name: _____ Acct #: _____

Are your present problems due to one of the following? □ An Illness □ A motor vehicle collision □ A personal injury
□ A motor vehicle collision □ A work related motor vehicle collision □ A work related injury □ No obvious reason
□ Other: _____
Enter the date of the injury, illness or onset: _____ _____ _____
Briefly describe the injury, illness or onset: _____
_____

List any symptoms you experienced IMMEDIATELY **after the injury:**

1. _____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

2. _____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

3._____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

4. _____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

List any symptoms you are experiencing **TODAY:**

1. _____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

2. _____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

3._____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

4. _____ **□(1) Very Mild □(2) □(3) □(4) □(5) □(6) □(7) □(8) □(9) □(10) Remarkably Severe**
Frequency of Pain: □ Occasional □ Intermittent □ Frequent □ Constant □ None
Type of Pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing □ Stinging □ Throbbing □ None

List any tests, studies or medications received for THIS issue:
□ Tests/Studies: _____
□ Medications: _____

Were you admitted to the hospital due to this issue? □Yes □No
If yes, what hospital? _____ Transported by? □Ambulance □Police □Other: _____
Date Admitted: _____ _____ _____ Date Released: _____ _____ _____ Length of Stay: _____hrs. _____days

Do you suffer from any condition other than that for which you are now consulting us? □Yes □No
If yes, what condition? _____

Name: _____ Acct #: _____

HISTORY

Past Treatments - List any past treatments you have had:

_____

Past Conditions - List any past conditions, not already indicated, you have had:

_____

_____

Family History - List any family health issues:

_____

_____

Social History - List any social history (smoking, drinking, etc.): Do you exercise? Yes No

How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Past Medications - List any past medications you have taken:

_____

Are you currently taking vitamins? If yes, which ones?

_____

Do you have allergies? □Yes □No If yes, which ones?

_____

Have you ever had any surgeries? □Yes □No If yes, enter the type and approximate date of surgery:

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

Champions Chiropractic Center
Review of Systems

Patient Name: _____ Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL
- ☐ Deny All
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Deny All
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

CARDIOVASCULAR
- ☐ Deny All
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

RESPIRATORY
- ☐ Deny All
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum Production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Deny All
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Deny All
- ☐ Breast Lumps / Pain
- ☐ Change in Nail Texture
- ☐ Change in Skin Color
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

GASTROINTESTINAL
- ☐ Deny All
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Deny All
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

ENMT
- ☐ Deny All
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Frequent Sore Throats
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ TMJ Problems
- ☐ Ulcers

NEUROLOGICAL
- ☐ Deny All
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Deny All
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss
- ☐ Substance Abuse
- ☐ Suicidal Indication
- ☐ Time Disorientation

ENDOCRINE
- ☐ Deny All
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

HEMATOLOGIC / LYMPHATIC
- ☐ Deny All
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC
- ☐ Deny All
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Champions Chiropractic Center, LLC for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Champions Chiropractic Center, LLC to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____

(If under age 18) Parent's signature

Name: _____ Acct #: _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle:_____

_____ _____
Signature Date

Consent to x-ray:

I hereby grant Champions Chiropractic Center LLC permission to perform an x-ray evaluation considered necessary or advisable in the course of examination and/or treatment. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

_____ _____
Signature (parent if minor) Date

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that ***I am ultimately held responsible for any unpaid balances***. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature_____ Date _____
(If under age 18) Parent's signature

Acknowledgement of Receipt of Notice of Privacy Practices

Champions Chiropractic Center, LLC
3960 Cypress Creek Pkwy
Houston, TX 77068

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ❑ The right to review the notice prior to signing this consent,
- ❑ The right to object to the use of my health information for directory purposes, and
- ❑ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Texas Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Texas Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: Date:

If not signed by the patient, please indicate relationship.

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused: (Efforts to Obtain/ Reasons for refusal)

_____
_____
_____