Welcome

Date:_____

Section 1: Demographics

Patient Name: _____, _____ □Male □Female
LAST FIRST

Birthdate: _____ Age:_____

S.S.#: _____

Address: _____City_____Zip_____

Cell #: _____(may we text your appt times? Yes or No) Home #: _____ _

Name of Cellular Provider for text reminder _____

E-Mail: _____

Referred by: _____

Married _____ Single _____ Divorced _____ Widowed _____

Section 2: Emergency Contact

If an emergency occurs, who should we contact: _____ Relation: _____

Phone #_____

Who is your medical doctor?: _____

6573 Old Jacksonville Hwy
Suite 100
Tyler, TX 75703
903-617-6106 (phone)
903-617-6857 (fax)

Section 3:

Our office policy:

We invite you to discuss with us any questions you may have regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If your account is not paid within 120 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting on your account. I authorize the provider and/or managed care organization, to release any information required to process insurance claims. I also authorize the staff to perform any necessary services needed during diagnosis and treatment.

I also understand that if I suspend or terminate my care at this office any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect on any balances. I authorize Flynn Chiropractic to obtain a credit report if deemed necessary.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform the office of any changes to the above information I have provided.

HIPAA

Patient Authorization for appointment reminders and scheduling related matters:

It is necessary for our staff to use your name, address and phone numbers for the purpose of contacting you to remind you of scheduled appointments, re-evaluations or other appointment related issues. The same information may be used to send monthly newsletters, chiropractic information, birthday cards, thank you cards and referral cards.

By signing the following consent you are acknowledging that you have read and understand the above information and that you authorize the staff of Flynn Chiropractic to contact you and leave messages for you at the above numbers and/or e-mail address below:

Acknowledge Receipt of Notice of Privacy Practices:

I acknowledge that I have received, reviewed and agree to the Notice of Privacy Practices of Flynn Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received and maintained by the practice.

Initial (Provided you have read and understand the above information):_____

Assignment of Benefits

I hereby authorize payment to be made directly to Flynn Chiropractic, of all benefits, which may be due and payable under insurance coverage for the named patient. I authorize utilization of this application or copies thereof for the purpose of processing insurance claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Flynn Chiropractic.

Authorization to Release Medical Information

Flynn Chiropractic is hereby authorized to disclose any part or all of the medical records of the named patient to such insurance companies, organizations or agencies that may be responsible for payment of services rendered by Flynn Chiropractic. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in denial of insurance coverage for services rendered by Flynn Chiropractic.

Informed Consent to Chiropractic Treatment

THE NATURE OF CHIROPRACTIC CARE:

The doctor will use his/her hands or mechanical device to move your joints. You may feel a "pop" or "click" similar to when a knuckle is cracked. In order to perform this, the doctor may place his/her hands on various parts of your neck, back, chest, hips, buttock, etc.. Various ancillary procedures such as rehabilitation, nutrition, ultrasound, acupuncture, electrical stimulation, massage, taping, heat, and ice may also be used.

SPINAL MANIPULATION RISKS AND COMPLICATIONS

Spinal Manipulation has been proven to be a very safe procedure. Studies have indicated that your risk of suffering a serious complication following a manipulation is remote. The bottom line: Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.
Initial (Provided you have read and understand the above information):_____

Fracture: Fractures caused from spinal manipulation are extremely rare. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Make sure to let your doctor know if you have a bone weakening condition.
_____ _____(initial)
TIA/Stroke: The best scientific evidence available has shown no causative relationship between appropriately applied cervical manipulation and stroke events. According to the literature, the risk of a stroke following an adjustment is 1 per 2-5.85 million adjustments. The incidence of a stroke in the population as a whole is no different than among those who receive manipulation treatment of the neck.
_____ _____(initial)

ALTERNATIVE FORMS OF TREATMENT:

Over the counter pain relieving products
Medical care
Physical Therapy
Hospitalization
Surgery.

I have read this form and am fully aware of the potential risks associated with spinal manipulation and agree to undergo Chiropractic care.

Signed:_____ Date:_____

Guardian: Signed:_____ Date:_____

6573 Old Jacksonville Hwy
Suite 100
Tyler, TX 75703
903-617-6106 (phone)
903-617-6857 (fax)

Health History

Please circle to indicate if you have had any of the following recently:

General
Allergy
Chills
Convulsions
Depression
Dizziness
Fainting
Headache
Loss of Sleep
Loss of Weight
Nervousness
Tremors

G-I
Belching/Gas
Colon Trouble
Constipation
Diarrhea
Difficult Digestion
Fall Bladder Trouble
Hemorrhoids
Jaundice
Liver Trouble
Nausea
Pain Over Stomach
Ulcers

Muscle/Joint
Arthritis
Bursitis
Hernia
Low Back Pain
Neck Pain/Stiffness

Pain or Numbness:
Between Shoulders
Shoulders
Arms
Elbows
Hands
Hips
Legs
Knees
Feet
Painful Tailbone
Sciatica
Swollen Joints

Respiratory
Chest Pain
Chronic Cough
Difficult Breathing
Coughing up Blood
Spitting up Phlegm
Wheezing

E.E.N.T.
Colds
Crossed Eyes
Deafness
Earache
Ear Noises
Enlarged Glands
Eye Flashes
Eye Pain
Hay Fever
Hoarseness
Nasal Obstruction
Nosebleeds
Sinus Infection
Sore Throat

Genito-Urinary
Bed Wetting
Blood in Urine
Frequent Urination
Can't Control Urine
Painful Urination
Prostate Trouble
Puss in Urine

Cardiovascular
Hardening Arteries
High Blood Pressure
Low Blood Pressure
Pain over Heart
Cold Hands or Feet
Rapid Heart Beat
Slow Beating Heart
Swelling Ankles
Varicose Veins

Skin
Bruise Easily
Dryness
Hives or Allergy
Itching
Skin Lesions (Rash)

Woman Only
Cramps/Backache
Excessive Flow
Hot Flashes
Irregular Cycle
Lumps in Breast
Menopausal Symptom
Painful Period
Miscarriage

List all medically diagnosed conditions: _____
List all injuries and dates: (including falls, broken bones, dislocations, etc.):
_____
List all surgeries and dates, including outpatient:
_____

Medications and Purpose	**Allergies**	**Vitamins/Supplements**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking Per day: _____
- ☐ Alcohol Per day: _____
- ☐ Caffeine per day: _____
- ☐ High Stress Level

Reason:_____

Woman Only
Last Period:_____
Are you Pregnant?
Yes No
Due Date:
_____

Your signature below will verify that all information you have given is accurate and complete.
Name:_____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

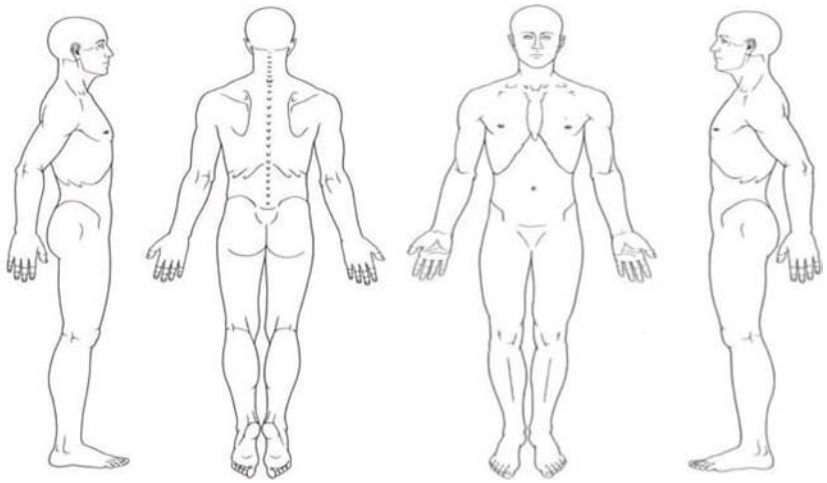
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____