

Patient Name: _____ Date: _____

Gender: M / F / Other Age: _____ Date of Birth: ____/____/____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Blood Type: A / AB / B / O Rh: + / -

Marital Status: _____ Occupation: _____

Primary Phone: _____ Secondary Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Health Conditions and Complaints: (list in order of severity)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Purpose of Appointment: (What are you hoping to gain from this experience?)

Allergies:

Current Medications and Supplements:

Name	Dosage	Frequency	Duration

Last Physical: _____ Results: _____

Last Lab Test: _____ Results: _____

Women: Date of Last PAP Smear: _____ Results: _____ Pregnant: Yes / No / Maybe

Men: Date of Last PSA/Prostate Test: _____ Results: _____

Medical Procedures, Hospitalizations, Injuries, Serious Illness:

Date	Procedure/Surgery/Illness	Outcome	Physician

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Print: _____ Date: _____

Lifestyle and Health Overview:

Do you follow any specific plan of eating? Y/ N If yes, which: _____

How many times a day do you eat? _____ How often do you eat out? Daily _____ Weekly _____

Digestion: Good / Adequate / Poor Symptoms: Acid Reflux / Burping / Bloating / Burning / Pain / Cramping / NA

Bowels Movements: Daily _____ Weekly: _____ Consistency: Normal / Hard / Soft / Diarrhea

Urination: Normal / Too Frequent / Sense of Urgency / Burning / Dribbling / Loss of Control / Wake at Night

Additional Complaints: _____

How much water do you drink daily? _____

Mark which you drink and how many a day (d) or week(w) you drink them:

Milk: _____ Herbal Tea: _____ Wine: _____

Coffee: _____ Soda: _____ Liquor: _____

Tea: _____ Beer: _____ Other: _____

Sleep: Restful / Restless / Hard to fall asleep / Wake Often / Wake to urinate / Nightmares / Night Terrors

What time do you go to sleep? _____ Number of hours of sleep per night? _____

Stress level 1 – 10 (10 being greatest): _____ Main Stressors: _____

How do you reduce stress? _____

Do you smoke? Y / N If yes, how many cigarettes and often? _____ How long have you smoked? _____

Drug Use (CONFIDENTIAL):

Recreational Drug Use: Y/N If yes: Marijuana / Cocaine / Heroin / Uppers / Downers / Other: _____

How often? _____ How long? _____

Women Only

Menstrual Cycle: Are you in menopause? Y / N If yes, are you still spotting or menstruating? Y / N

Do you have monthly periods? Y / N Date of Last Period: _____ Cycle Length: _____

Flow: Normal / Spotting / Light / Heavy Symptoms: Cramps / Bloating / Weak / Mood Swings / Cravings / Pain / Clotting

Are you currently pregnant? Y / N Trying to conceive? Y / N Total number of pregnancies: _____

How many live births? _____ Are you breastfeeding? Y / N

Remember to list any supplements or medications on the first page.

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Print: _____ Date: _____

Toxicity Questionnaire

Please circle a number in each of the following categories based on your health in the last 30 days.

0=Rarely/never experience the symptom **1**=Occasionally experience but effect is not severe
2=Occasionally experience but effect is severe **3**=Frequently experience and effect is not severe
4=Frequently experience and effect is severe

Digestive:		Hormones:		Ears, Sinus, Nose:	
Gas, Belch, Bloating	0 1 2 3 4	Oily skin, Acne	0 1 2 3 4	Popping ears	0 1 2 3 4
Heartburn, Reflux	0 1 2 3 4	Pain during period	0 1 2 3 4	Fluid in ears	0 1 2 3 4
Nausea	0 1 2 3 4	Breast tenderness	0 1 2 3 4	Ring ear, Hearing loss	0 1 2 3 4
Strain on bowel mvmt	0 1 2 3 4	Irregular Cycle	0 1 2 3 4	Earaches, Infections	0 1 2 3 4
Day w/o bowel mvmt	0 1 2 3 4	Weight Gain	0 1 2 3 4	Excessive mucous	0 1 2 3 4
Diarrhea, Vomiting	0 1 2 3 4	Cry easily	0 1 2 3 4	Stuffy Nose	0 1 2 3 4
Hemorrhoids	0 1 2 3 4	Vaginal dryness	0 1 2 3 4	Sinus Headache	0 1 2 3 4
Total for section:	_____	Hot flashes	0 1 2 3 4	Nose bleeds	0 1 2 3 4
Heart:		Loss of sex drive	0 1 2 3 4	Total for section:	_____
Shortness of breath	0 1 2 3 4	Erectile dysfunction	0 1 2 3 4	Mouth, Throat, Teeth:	
Tightness in chest	0 1 2 3 4	Balding	0 1 2 3 4	Dry mouth	0 1 2 3 4
Chest pain	0 1 2 3 4	Anger easily	0 1 2 3 4	Canker sores	0 1 2 3 4
Rapid, Skipped heartbeat	0 1 2 3 4	Total for section:	_____	Tooth pain	0 1 2 3 4
High, Low Blood Pressure	0 1 2 3 4	Head, Eyes:		Bleeding gums	0 1 2 3 4
Total for section:	_____	Blurred vision	0 1 2 3 4	Gagging, Clearing throat	0 1 2 3 4
Emotions:		Pressure head/eyes	0 1 2 3 4	Total for section:	_____
Mood swings	0 1 2 3 4	Faintness	0 1 2 3 4	Lungs:	
Anger, Irritability	0 1 2 3 4	Dizziness	0 1 2 3 4	Difficulty breathing	0 1 2 3 4
Anxious, Fearful, Nervous	0 1 2 3 4	Headaches	0 1 2 3 4	Chest congestion	0 1 2 3 4
Panic attacks	0 1 2 3 4	Total for section:	_____	Coughing	0 1 2 3 4
Sense of Despair	0 1 2 3 4	Allergies:		Asthma	0 1 2 3 4
Depression	0 1 2 3 4	Watery, Itchy Eyes	0 1 2 3 4	Total for section:	_____
Total for section:	_____	Runny nose	0 1 2 3 4	Joints, Muscle, Bone:	
Energy:		Sneezing	0 1 2 3 4	Twitching	0 1 2 3 4
Restlessness	0 1 2 3 4	Itchy throat	0 1 2 3 4	Cramping	0 1 2 3 4
Hyperactivity	0 1 2 3 4	Itchy skin	0 1 2 3 4	Stiff and achy joints	0 1 2 3 4
Brain fog	0 1 2 3 4	Post nasal drip	0 1 2 3 4	Pain in joints	0 1 2 3 4
Sluggishness	0 1 2 3 4	Total for section:	_____	Muscle ache	0 1 2 3 4
Fatigue, Tired	0 1 2 3 4	Immune:		Muscle pain	0 1 2 3 4
Swelling hands and feet	0 1 2 3 4	Frequent illness	0 1 2 3 4	Osteoporosis	0 1 2 3 4
Total for section:	_____	Sore throat	0 1 2 3 4	Numbness, Burning	0 1 2 3 4
Skin, Hair, Nails:		Fever	0 1 2 3 4	Flat feet, Fallen arch	0 1 2 3 4
Flushing	0 1 2 3 4	Genital itch, Discharge	0 1 2 3 4	Total for section:	_____
Cold hands and feet	0 1 2 3 4	Yellow nail fungus	0 1 2 3 4	Sleep:	
Acne	0 1 2 3 4	Total for section:	_____	Inability to fall asleep	0 1 2 3 4
Dry skin / Oily skin	0 1 2 3 4	Urinary Tract:		Wake up often	0 1 2 3 4
Hives, Rashes	0 1 2 3 4	Frequent urination	0 1 2 3 4	Nighttime urination	0 1 2 3 4
Eczema, Psoriasis	0 1 2 3 4	Burning on urination	0 1 2 3 4	Wake up tired	0 1 2 3 4
Hair loss	0 1 2 3 4	Dribbling urine	0 1 2 3 4	Bad Dreams, Nightmares	0 1 2 3 4
Cracked heels on feet	0 1 2 3 4	Leaky bladder	0 1 2 3 4	Night sweats	0 1 2 3 4
Bruising	0 1 2 3 4	Blood in urine	0 1 2 3 4	Total for section:	_____
Brittle nails	0 1 2 3 4	Kidney stones	0 1 2 3 4		
Total for section:	_____	Total for section:	_____		

Pain Questionnaire

We realize you may consider that two or more statements in any one section apply but please just circle one number that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

1. I have no pain at the moment
2. The pain is very mild at the moment
3. The pain is moderate at the moment
4. The pain is fairly severe at the moment
5. The pain is very severe at the moment
6. The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

1. I can look after myself normally without causing extra pain
2. I can look after myself normally but it causes extra pain
3. It is painful to look after myself and I am slow and careful
4. I need some help but manage most of my personal care
5. I need help every day in most aspects of self-care
6. I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

1. I can lift heavy weights without extra pain
2. I can lift heavy weights but it gives extra pain
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
5. I can lift very light weights
6. I cannot lift or carry anything at all

Section 4 – Walking*

1. Pain does not prevent me walking any distance
2. Pain prevents me from walking more than 1 mile
3. Pain prevents me from walking more than ½ mile
4. Pain prevents me from walking more than 100 yards
5. I can only walk using a stick or crutches
6. I am in bed most of the time

Section 5 – Sitting

1. I can sit in any chair as long as I like
2. I can only sit in my favourite chair as long as I like
3. Pain prevents me sitting more than one hour
4. Pain prevents me from sitting more than 30 minutes
5. Pain prevents me from sitting more than 10 minutes
6. Pain prevents me from sitting at all

Section 6 – Standing

1. I can stand as long as I want without extra pain
2. I can stand as long as I want but it gives me extra pain
3. Pain prevents me from standing for more than 1 hour
4. Pain prevents me from standing for more than 30 minutes
5. Pain prevents me from standing for more than 10 minutes
6. Pain prevents me from standing at all

Section 7 – Sleeping

1. My sleep is never disturbed by pain
2. My sleep is occasionally disturbed by pain
3. Because of pain I have less than 6 hours sleep
4. Because of pain I have less than 4 hours sleep
5. Because of pain I have less than 2 hours sleep
6. Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

1. My sex life is normal and causes no extra pain
2. My sex life is normal but causes some extra pain
3. My sex life is nearly normal but is very painful
4. My sex life is severely restricted by pain
5. My sex life is nearly absent because of pain
6. Pain prevents any sex life at all

Section 9 – Social life

1. My social life is normal and gives me no extra pain
2. My social life is normal but increases the degree of pain
3. Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sport
4. Pain has restricted my social life and I do not go out as often
5. Pain has restricted my social life to my home
6. I have no social life because of pain

Section 10 – Travelling

1. I can travel anywhere without pain
2. I can travel anywhere but it gives me extra pain
3. Pain is bad but I manage journeys over two hours
4. Pain restricts me to journeys of less than one hour
5. Pain restricts me to short necessary journeys under 30 minutes
6. Pain prevents me from travelling except to receive treatment.

Total: _____

Financial Policies

Patients without Assignable Insurance Coverage (Self-Pay):

Payments may be made by cash, personal check, or charged to American Express, Discover Card, MasterCard, or Visa and are expected at time of services rendered. At your request, we will provide a receipt that will itemize your charges with our clinic. Various payment plans can be arranged to accommodate your medical and financial needs. We also offer a 20 % discount to your charges when patients pay at time of service (not applicable to payment plans).

Patients with Assignable Insurance Coverage:

It is important that you understand your health and accident insurance. The agreement to pay for your chiropractic care is a contract **between you and your insurance company**. As a courtesy, our office takes assignment of verifiable insurance. Our office will complete any necessary forms to collect from your insurance company. Any amount paid directly to our office by the insurance company will be credited to your account.

Most insurance policies do cover chiropractic services, but the amount they paid varies from one policy to another. Some may pay 100% and some may only pay a small amount. Others may have limits on accepting insurance assignment. Your co-pay or percentage is to **be paid at the time of service** throughout your course of treatment. When insurance payments are received on an account, the patient is still responsible for any difference between the filed charges and payments received. Be assured that if the difference is a filing problem, we do everything we can to correct it before asking the patient to pay.

We will supply the insurance company with the customary progress reports, but if for any reason they require a more detailed report, out of the ordinary, the insurance company will be charged accordingly.

Our office **DOES NOT GUARANTEE** that your insurance company will pay. However, we do call and verify chiropractic coverage in an effort to eliminate any surprises to you the patient. During your first visit we will go over your coverages as it was relayed to us.

In some instances, when following up on a claim unpaid by the insurance, we may at one point ask for your assistance, as the original contract is between the insured and their insurance company.

At this time, we only accept PPO insurance plans. Most plans do not cover all services that are offered by this office. We do our best to keep you advised of any services that are not covered. If for some reason your coverage has lapsed or canceled you are also responsible any balance accrued. *** Your signature on this office policy indicates that you will assume responsibility for these services. ***

Patients Covered by Worker's Compensation:

We must have a verification from your employer that your injury has been reported and that an E1 (Employer's Report) has been filed with the Texas Worker's Compensation Commission. Workman's Comp pays for all approved care. You may still be responsible for uncovered items, such as nutritional aids and vitamins.

Supportive or Maintenance Care:

Your insurance company has specific limitations regarding your care and will only pay for what it considers to be **medically necessary** for the resolution of your specific problem. To put it simply, insurance companies are not interested in wellness care. Any care provided to improve your general health and well-being beyond what your insurance company is willing to cover will be billed on a cash basis.

Nutritional Evaluations:

Nutritional evaluations, testing and treatment are not covered services under most insurances. Our office policy is that payment is always expected at the time of services rendered.

Payment Policy Agreement (abbreviated):

I understand and agree that my health/accident insurance policies are an arrangement between my insurance carrier and myself. I understand and agree that I am personally responsible for payment of all services rendered to me, and any minor that is covered under my policy.

I also understand that if I suspend or terminate care, any fees for services rendered will be due immediately.

I hereby acknowledge that I have read and understand the full payment policy of this office and agree to abide by its guidelines.

Signature of Patient / Legal Representative: _____

Relationship to Patient: _____

Date: _____

Insurance Assignment and Authorization:

I hereby direct my insurance company, _____ to pay Galloway Chiropractic Clinic LLC the sum of the proceeds payable under the terms of my insurance policy for dates of services seen in association with Galloway Chiropractic Clinic LLC.

I specifically authorize that this assignment may be paid from disability benefits, medical payments or from any benefits due me under this claim.

I also authorize Galloway Chiropractic Clinic LLC to release any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signature: _____

Date: _____

Witness: _____

Date: _____

Fax and E-mail Authorization Form

In order to communicate with you by fax or e-mail, Galloway Chiropractic LLC requires the following information. All information is kept strictly confidential and is used only for our purposes.

Fax Number: _____

E-mail Address: _____

I understand that fax and e-mail communications are not secure forms of communication and that confidentiality of any e-mail or fax cannot be ensured.

I authorize Galloway Chiropractic LLC to Fax and E-mail correspondence, request for information and other documents to me whenever possible.

Printed Name: _____

Signature: _____

Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone: _____ E-mail: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to Galloway Chiropractic Clinic LLC’s use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Persons Authorized to Use or Disclose Information: Information will be used by or disclosed by:

- 1. Galloway Chiropractic Clinic LLC
- 2. Name: _____

Who can we release information to / speak to about your care?

Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative’s Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation.

I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Authorization and Consent to Treat

The following is provided so that we might have a common understanding of our rights and roles in professional therapeutic relationship. Please read and sign this agreement indicating that you understand and agree to the following. Please ask any questions if you would like further information about any of the following.

1. Information revealed during counseling and treatment sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the legal authorities compel us to do so.
2. Each procedure or treatment carries with it both risks and benefits. There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and customized to your unique health status and your personal goals, no guarantees can be assured regarding the outcomes of treatment.
3. Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor know if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.
4. Physical examination, chiropractic treatment, and neuro-muscular therapy involves physical contact and may be uncomfortable for some persons. If you are uncomfortable with physical contact or unfamiliar with chiropractic please let the doctor know so that they can assist you and help you find an alternative that is more comfortable for you.
5. You are welcome to bring a friend or relative to your visits if such companionship is comfortable for you.
6. You are encouraged to ask questions on any health-related topic and to take an active role in your health care. This office offers a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyle that can help you attain you highest level of health.
7. The doctor may not be available at all times. If you have a serious health problem that requires immediate attention, you should call your other doctors, call 911, or have someone take you to the nearest hospital or emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it and contact the doctor and relate what has occurred as soon as possible.
8. It may become necessary at various times to contact you by phone, mail, or e-mail. By signing this form, you are giving us your permission to contact you by one of the above methods.

The new patient information, health history, and other information that I provided on my intake form are complete and accurate. I understand and agree to the information on this page. My questions, if any, were answered to my satisfaction.

Signature of Patient / Legal Representative: _____

Relationship to patient: _____

Date: _____

Consent for Minor: I acknowledge that I have read and understand the above consent to treat information and authorize and give consent to the doctor(s), staff, and doctor assistants of Chiropractic Works to treat my minor child. As of today's date, I have the legal right to select and authorize health care service for the minor child named below. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Print Child's Name: _____

Relationship to Child: _____

Parent/Guardian Print & Sign Name: _____

Date: _____