WELCOME *Patient Information*

Name: _____
Last First M

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone # (H) _____ (W) _____ (Other) _____

Email address: _____ Sex: ❑ Male ❑ Female SS#: _____

Date of Birth: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? We would love to thank them! _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Reason for Visit?_____

When did your symptoms appear?_____ Is this condition getting progressively worse? □Yes □No □ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting □Burning □Tingling □Cramps □Stiffness □Swelling

□Other How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your □Work □Sleep □Daily Routine □Recreation

Indicate activities which are painful to perform: □ Sitting □ Standing □ Walking □ Bending □Lying Down

What treatment have you already received for your condition? □ Medication □ Surgery □ Physical Therapy

□ Chiropractic Services □ None □ Other_____

Name and address of other doctor(s) who have treated you for your condition:

_____

_____

Date of Last: Physical Exam_____ Spinal Exam/X-Ray_____ Lab work_____

Chest X-Ray_____ MRI, CT-Scan, Bone Scan_____

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Work Comp. ☐ Other

What activities would you like to do if this was not a problem? _____

What have you tried to help relieve/get rid of this problem and how much did it help?

◆ Medications: Helped: ___Little ___Some ___Much
◆ Physical Therapy: Helped: ___Little ___Some ___Much
◆ Chiropractic Helped: ___Little ___Some ___Much
◆ Exercise: Helped: ___Little ___Some ___Much
◆ Nutrition: Helped: ___Little ___Some ___Much
◆ Stretching: Helped: ___Little ___Some ___Much

Health History

Who is your primary care physician? (Doctor and/or practice) _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

Please list any medication or general allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Do you have any surgical devices in your body? (i.e. screws, pins, plates, etc?) ❑ Yes ❑ No If yes, where: _____

ACTIVITY LEVEL: select one of the following:

☐ Inactive: no regular physical activity with a sit-down job
☐ Light Activity: no organized physical activity during leisure time
☐ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
☐ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.
☐ Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week.

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____

❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

***Habits*:** (please select all that apply): □ Smoking Packs/day: _____ □ Alcohol Drinks/week: _____
□ Coffee/Caffeine drinks Cups/day: _____ □ High Stress level Reason: _____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

☐ There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

Insurance Information

Policy Holder Name: _____ D.O.B.:_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

ASSIGNMENT AND RELEASE

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay The Oaks Healthcare Center the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of any health insurance or medical plan benefits directly to The Oaks Healthcare Center for medical services rendered and for any supplies, tests, or medications provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other legal remedies necessary in connection with same. I hereby assign directly to The Oaks Healthcare Center all current and prior rights, if any, to payment and benefits and all legal and other health plan rights that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). This assignment includes, but is not limited to, a designation that The Oaks Healthcare Center personnel can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to The Oaks Healthcare Center as a result of services rendered by The Oaks Healthcare Center and authority to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

FINANCIAL POLICY: We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard , Discover and Care Credit. I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements and I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE _____ **DATE** _____

Informed Consent to Care

Chiropractic care is a system that uses the recuperative powers of the body and the relationship between the musculoskeletal structure and functions of the body in the restoration and maintenance of health. The treatment involves "hands-on" joint manipulation. Please read and consent below:

- The details of the treatment including the anticipated benefits and material risks have been/will be explained to me in terms I understand. I understand I should ask if anything is unclear.
- Alternative methods and therapies, their benefits, material risks and disadvantages have been/will be explained to me. I understand and accept that the most likely material risks and complications of chiropractic care have been discussed with me

and may include but are not limited to: *fatigue following manipulation, headache, radiating discomfort, treatment unsuccessful in its intended purpose/no relief, worsening of condition being treated*

- I understand and accept the less common complication of stroke following manipulation of the neck.

- I have informed the doctor of all previous operations, including but not limited to, spinal fusion and acute fractures and dislocations.

- I have informed the doctor of my past medical history, including but not limited to history of hypertension and/or cardiac conditions. I have informed the doctor whether I have musculoskeletal problems, such as osteoporosis, bone or joint infections, bone cancer, acute rheumatoid arthritis, and/or disease of the spinal cord or bone marrow.

- I am aware and accept that no guarantees about the results of the treatment have been/will be made. I have been/will be informed of what to expect post treatment, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional treatments.

Our Family Nurse Practitioner provides medicinal, minor surgical and injection therapies as well. Please initial your understanding and consent below:

- The details of the procedure including the anticipated benefits and material risks have been/will be explained to me in terms I understand. Alternative methods and therapies, their benefits, material risks and disadvantages have been/will be explained to me. I understand and accept that the most likely material risks and complications of drug therapy and injections to be discussed with me and may include but are not limited to: Infection/irritation at injection site. Adverse reactions to medicine.

- I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any medical or surgical procedure.

- I am aware that smoking could increase chances of complications &/or reduce the efficacy of my therapy.

- I have informed the doctor of all my known allergies. I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use. I have been/will be advised whether I should avoid taking any or all of these medications on the days surrounding the procedure. I understand I should ask if anything is unclear.

- I am aware and accept that no guarantees about the results of the procedure have been made.

- I have been/will be advised of the probable consequences of declining recommended or alternative therapies. I have been/will be informed of what to expect post-treatment, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

- I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature. This notice is effective, as of this signature date and will expire seven years after the date on which you last received services from us.

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Printed patient or guardian name Relationship to patient

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please initial below:

I acknowledge that I have reviewed the Notice of Privacy Practices of The Oaks Healthcare Center.

Yes or No **I request a copy of the Privacy Notice at this time.** I acknowledge that I can request a copy at any time and the Privacy Notice is readily available in the office.

_____ I agree that my email address can be used by The Oaks Healthcare Center to send me information each month that may include educational articles, office events & schedule changes and monthly specials. I further understand that I am free to opt out of email communication at any time.

_____ I acknowledge that it is the policy of The Oaks Healthcare Center to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dawn Bush, about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

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

_____ _____
Parent/Guradian's Signature Date

Patient Name: _____ Date: _____/_____/_____

INDEX (REVISED OSWESTRY) **Please read instructions carefully.**

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE

- ☐ I do not have to change my way of washing or dressing to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – LIFTING

- ☐ I can lift heavy objects without any extra pain.
- ☐ I can lift heavy objects, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor.
- ☐ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ☐ I can only lift very light objects at the most.

SECTION 4 – WALKING

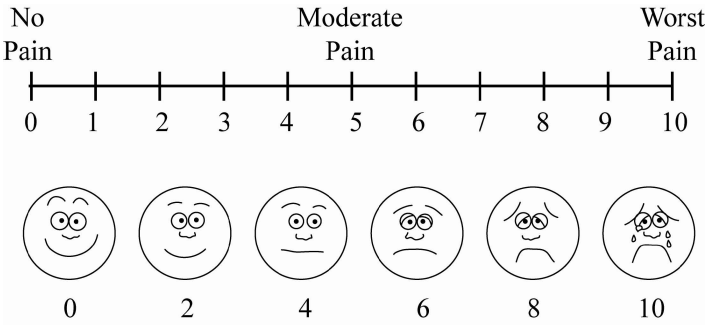
- ☐ I have no pain on walking.
- ☐ I have some pain - it does not increase with distance.
- ☐ I can't walk more than one mile without increasing pain.
- ☐ I can't walk more than ½ mile without increasing pain.
- ☐ I can't walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than half an hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain.

SECTION 6 – STANDING

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain.



SECTION 7 – SLEEPING

- ☐ I get no pain in bed.
- ☐ I get pain bed but it does not prevent me from sleeping well.
- ☐ Pain reduces my normal sleep by ¼ each night.
- ☐ Pain reduces my normal sleep by ½ each night.
- ☐ Pain reduces my normal sleep by ¾ each night.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ My social life is unaffected by pain apart from limiting more energetic interests.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – DRIVING / RIDING IN CAR, ETC.

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Cancellation and Missed Appointment Policy for The Oaks Healthcare Center

Our goal is to provide quality individualized health care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of health care.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please be courteous and call our office promptly at 281-852-8724 if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. **If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance.**

How to Cancel Your Appointment

To cancel appointments, please call 281-852-8724. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations & No Show Policy:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice. A "no-show" is someone who misses an appointment without cancelling it as above. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- First missed appointment: there will be no charge
- Second missed appointment: $25 fee will be billed to your account

Financial Policy & Agreement:

I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments. I authorize The Oaks Healthcare Center to charge my credit card listed below, which will be kept on file, any amounts not covered by my insurance company including but not limited to copayments and amounts determined by my insurance to be my responsibility and any fees associated with no-show/late appointments.
_____***Initial Here***
By signing below, I acknowledge and agree to the Financial Policy and Agreement and I further instruct my credit card issuer to honor any charges subject to the above policies.

_____ _____
Signature Date

Please provide the following information:

Name on card: _____ Visa___ MC___ Discover___ AmEx___

Credit card number: _____ Exp date: _____ Sec Code: _____

Billing address: _____ City: _____ State: _____ Zip: _____