PATIENT INFORMATION

Date: _____ **Medicare? Y or N Medicare #** _____

Name: _____ (Age) _____**Date of Birth** _____/_____/_____ Gender: M F

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____ Preferred Method of contact? ☐ Cell ☐ Home ☐ Email

Cell Phone: ( ) _____ **Home Phone: ( ) _____**

Social Security #: _____ - _____ - _____ Marital Status: S M D W Spouse's Name: _____

Occupation: _____ Employer Name: _____ How long: _____ months / years

Number of Children: _____ Ages: _____ How were you referred to this office? _____

In case of Emergency, contact _____ Phone ( ) _____ Relationship _____

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: _____

HEALTH LIFESTYLE

Do you smoke? Yes No If yes, how many packs per week? ___ Have you ever smoked in the past? Yes No When did you quit? __

Do you consume alcohol? Yes No If yes, how many drinks per week? _____

Do consume caffeine? Yes No If yes, how many drinks per day? _____

Do you exercise? Yes No If yes, how many times per week and what type? _____

Do you have a high stress level? Yes No If yes, list reasons:_____

Please list all past surgeries and dates: _____

Please list any hospitalizations: _____

Please list all previous accidents and falls: _____

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

Please list any health conditions not mentioned: _____

Please list any medications currently taking. Purpose:

_____ _____

_____ _____

_____ _____

Family History:

Any immediate family members (mom, dad, siblings, grandparents) have or have had any of the following:
Heart Disease Cancer Diabetes, Arthritis, Other

Who and what is the current status of your loved one? _____

PURPOSE OF THIS VISIT

CURRENT COMPLAINTS-List current symptoms separately in order of severity.

Please mark areas of pain on the figures below

1st Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? □ Constant 100% □ Frequent 75%
□ Intermittent 50% □ Occasional 25% □ Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

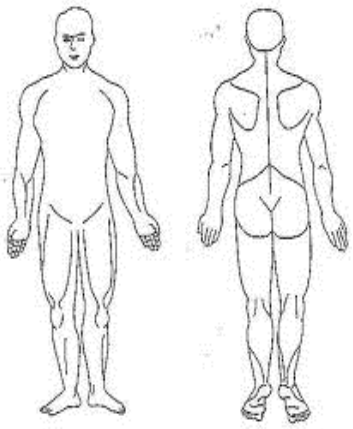
Type of pain? □ Sharp □ Dull □ Aching □ Burn □ Throb □ Numb

□ Other _____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

Where does pain radiate to? _____



2nd Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? □ Constant 100% □ Frequent 75%
□ Intermittent 50% □ Occasional 25% □ Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

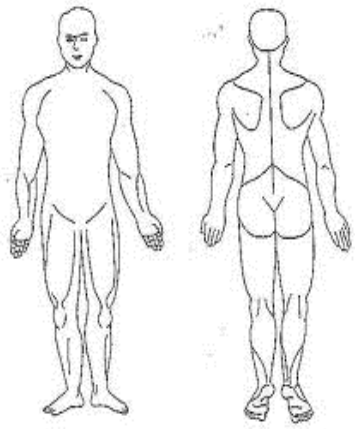
Type of pain? □ Sharp □ Dull □ Aching □ Burn □ Throb □ Numb

□ Other _____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

Where does pain radiate to? _____



3rd Body Part: _____

Date symptom first appeared: _____

How often do you experience these symptoms? □ Constant 100% □ Frequent 75%
□ Intermittent 50% □ Occasional 25% □ Rare 10%

What makes symptom increase? _____

What makes symptom decrease? _____

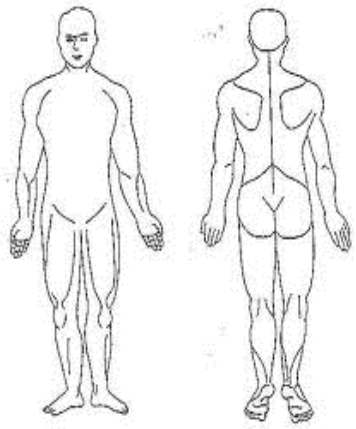
Type of pain? □ Sharp □ Dull □ Aching □ Burn □ Throb □ Numb

□ Other _____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

0 1 2 3 4 5 6 7 8 9 10

Where does pain radiate to? _____



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 vertebrae 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 its maximum health potential.

Assignment of Benefits Form

Financial Responsibility

I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time-of-service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

____ Initials

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/auto plan, to issue payment check(s) directly to **Temple Sport and Spine Chiropractic LLC** for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

____ Initials

Authorization to Release Information

I hereby authorize **Temple Sport and Spine Chiropractic LLC** to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

____ Initials

I have requested medical services from **Temple Sport and Spine Chiropractic LLC** on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any, and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature **Date**

INFORMED CONSENT

Patient Name: _____

Clinic Name: Temple Sport and Spine Chiropractic LLC

Doctor's Name: Dr. Bill Wallar D.C.

Address: 201 Paloma Drive Temple, Texas 76502

Phone: (254) 598-1155 Fax: (254) 262-0052

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature (if a minor) Parent/Guardian Printed Name

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature (if a minor) Parent/Guardian Printed Name