

Pulse Chiropractic
2450 Fondren, Suite 105
Houston, Texas 77063

Date _____

Patient's Name _____

Patient's Address _____ City _____ State _____ Zip Code _____

Age _____ D.O.B. _____ Single Married Divorced Widowed No. of children _____

Occupation _____ Employer _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Mate's Name _____ Mate's DOB: _____

Are you insured? Yes No Name of Insurance Co. _____

Please list your family physician. May we have your permission to contact them? Yes No

Emergency Contact _____ Relationship _____ Contact Phone _____

Who referred you? _____ Date of last physical exam _____

What is the reason for today's appointment?

Primary condition: _____

Condition 1: _____

Condition 2: _____

Are all the above condition(s) due to an Auto Accident? Yes No or Work Related Injury? Yes No

Condition(s) began when and how? _____

What is the Quality of the complaints/pain? dull aching sharp shooting burning throbbing
 deep nagging Other _____

Does this condition/pain radiate or travel (shoot) to any other areas of your body? Yes No Where? _____

Do you have numbness or tingling in your body? Yes No Where? _____

Grade Intensity/Severity 0 1 2 3 4 5 6 7 8 9 10

(Where "0" is No complaint/pain and where "10" is the Worst pain/complaint imaginable)

How frequent are condition(s) present, how long does it last? _____

Does anything aggravate the condition(s)? Yes No Describe _____

Does anything make the condition(s) better? Yes No Describe _____

Describe interventions, treatments, medications, surgery or care that you've sought for your condition:

Past Health History

Previous Illnesses: _____

Previous Injury/trauma: _____

Broken bones? Which? _____

Allergies: _____

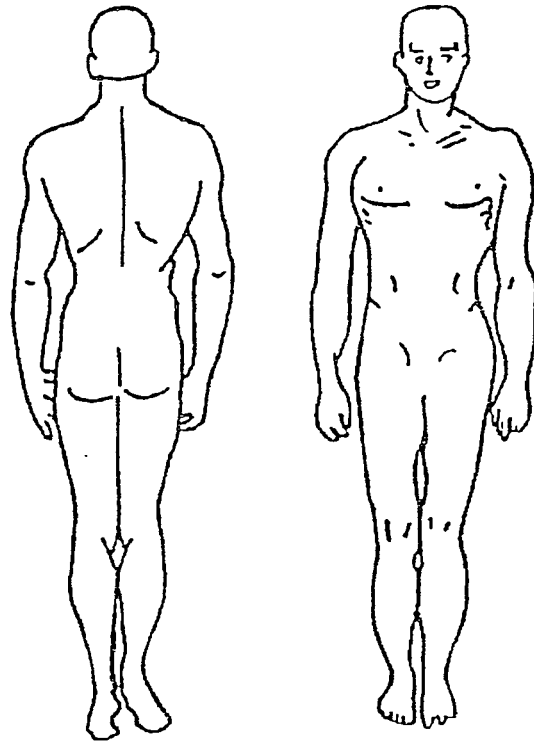
Initials 

Please Fill In Below

If you have had the following, or if you suffer from the following, Please Check below...

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Ringling in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Female Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problem	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>

Circle the areas where you have any problems.
Please describe these problems.



Please fill in below, any other health information you feel that we might need for your wellbeing and care.

Thank you for being complete and thorough.

Please sign below



Today's Date _____

Pulse Chiropractic

Medications:

- 1. _____
- 2. _____

Reason for taking this medicine

Surgeries:

- 1. _____
- 2. _____

Type of surgery

Females What was the date of your last menstrual period? _____ Are you pregnant now? Yes No
Lifestyle

How often do you exercise? Daily Weekly Sometimes Never

How often do you drink alcohol? Daily Weekly Sometimes Never

How often do you smoke? Daily Weekly Sometimes Never

Do you use recreational drugs? Daily Weekly Sometimes Never

How is your diet? Healthy Healthy Sometimes Fast Food

Auto Accident?

My Auto Insurance Co. _____ Claim # _____

Adjuster's Name _____ Adjuster's Phone # _____

Date of Injury _____ Time of Day _____ Location _____

Please describe the accident _____

Is there any other Insurance Co involved? Yes No Do you have an attorney? Yes No

Insurance Co. Name _____ Attorney's Name _____

Phone # _____ Phone # _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Person responsible for payment _____

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**Patient Consent for Purpose of Treatment,
Payment and Health Care Operations**

I acknowledge that Pulse Chiropractic Clinic's *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* described the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Pulse Chiropractic Clinic. I understand that I have the right to review the *Notice of Privacy Practices* prior to signing this document and the right to request restrictions as to how my health information may be used.

I understand that I may revoke this consent in writing, except in the instance Pulse Chiropractic Clinic has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, Pulse Chiropractic Clinic may refuse to treat me. I understand that Pulse Chiropractic Clinic reserved the right to change its *Notice of Privacy Practices*. I may obtain a revised *Notice of Privacy Practices* by mail or in person.

Patient Name (Please print) _____ Date of Birth _____

Representatives Authorized to Act for Patient _____

Patient Signature _____ Date _____

Specific Health Care Authorization

The patient identified below authorized Pulse Chiropractic Clinic to use and or disclose and *Protected Health Information* in accordance with the following:

1. I give Pulse Chiropractic Clinic authorization to use my address, phone number, e-mail and clinic records to contact me with holiday cards, cards of other occasions and health related information.
2. I give Pulse Chiropractic Clinic authorization to treat me in an open room. Should I need to speak with the doctor in private, the doctor will provide this.

You have the right to revoke this authorization in writing, at any time. However, your request to revoke this authorization is not effective to the extent that we have provided services or take action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to the Privacy officer of Pulse Chiropractic Clinic. The written notice must contain your name, date of birth, a clear statement of your intent to revoke this authorization, the date of your request and your signature. This revocation is not effective until it is received by the Privacy officer.

This authorization is requested by Pulse Chiropractic Clinic for its own use and disclosure of *Protected Health Information*.

Signature of patient

Date

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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including a comprehensive exam, diagnostic x-ray(s), physical therapy techniques, or me (or on the name patient below for which I am legally responsible) which are recommended by Katherine S. Pulse, D.C. and or any other licensed doctors or chiropractic who now or in the future render treatment to me which employed by, associated with or observing as a backup for **Pulse Chiropractic Clinic**.

I understand that, as with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This is a very rare occurrence (a one in one to three million chance). I understand that **Pulse Chiropractic Clinic** screens patients for indications that they are candidates for chiropractic manipulation to the best of their ability. I do not expect the doctor to be able to anticipate all risk and complications during the course of the procedure(s) which the doctor feels at the time, based on the facts then known, are in my best interest.

I have had an opportunity to discuss with Katherine S. Pulse, D. C. and/or with office personnel the nature, purpose and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are no guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest o undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Print name of patient

Signature of patient

Date

Signature of patient's representative
(If patient is a minor)

Date