VICTORY
CHIROPRACTIC

Patient Contact Information

Victory Chiropractic | 330 Genesis Blvd Suite B, Webster, TX | Tel: (281) 724-1620

Title: **First:** **Middle:** **Last:** **Nickname:**

Date of Birth: **Sex:** **Male / Female** **Do you have children?** ○ **Yes** ○ **No** **Ages:**____________________

Address: **City:** **State:** **Zip Code:**

Primary/Cell Phone Number: **Email:**

Employment (circle one): **Employed** **Part-Time Student** **Full-Time Student** **Retired** **Other**

Occupation: **Employer:**

Marital Status (circle one): **Single** **Married** **Other:**_______________ **Spouse's Name:**

Referred By: **How May We Contact You? (circle all that apply):** **Phone** **Email**

Other Family Members Seen Here:

CONFIDENTIALITY QUESTIONNAIRE

In order to comply with HIPPA guidelines (effective 4-12-03), it is necessary for you to complete the following information: Who may we inform about your general medical condition, diagnosis, test results or treatment plan? This includes, but is not limited to general questions about your condition. Please include your Primary Care and/or Referring Physician if necessary.

Name	**Relation**	**Phone**

Consent to Treatment (Minor)

I hereby request and authorize Victory Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter __________________________. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

*********PLEASE NOTE**********

I understand that this consent will remain in effect until revoked IN WRITING by myself, or my legal guardian/parent.

____________________ ____________________ ____________________

Signature **Date** **Relationship**

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Patient Medical History

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Name of your Family Doctor/Primary Care Physician?

What City and State?

Date of Last Visit: / /

Date of Last Exam: / /

Past Surgeries (year):

The Reason For This Visit:

Have you been treated by a Medical Physician for this condition? ○ Yes ○ No

If so, who, when & where?

Have you ever been treated by a Chiropractor before? ○ Yes ○ No **Was it for the current condition?** ○ Yes ○ No

If so, who, when & where?

Present/Past Illness/Condition(s): (circle all that apply)

AIDS	Cancer	Emotional Difficulties	Low Blood Pressure	Spinal Disc Disease	
Allergies	Cirrhosis/Hepatitis	Hay Fever	Mental Illness	Rheumatic Fever	Tuberculosis
Anemia	Diabetes	Heart Problem	Mulitple Sclerosis	Scoliosis	Ulcer
Arthritis	Dislocated Joints	High Blood Pressure	Pacemaker	Sinus Trouble	
Asthma	Diverticulitis	HIV/ARC	Polio	STD	
Bone Fracture	Epilepsy	Kidney Trouble	Prostate Trouble	Thyroid Trouble	

Others:

Current Medications:

Family History of Illness: (circle all that apply)

AIDS	Cancer	Emotional Difficulties	Low Blood Pressure	Spinal Disc Disease	
Allergies	Cirrhosis/Hepatitis	Hay Fever	Mental Illness	Rheumatic Fever	Tuberculosis
Anemia	Diabetes	Heart Problems	Multiple Sclerosis	Scoliosis	Ulcer
Arthritis	Dislocated Joints	High Blood Pressure	Pacemaker	Sinus Trouble	
Asthma	Diverticulitis	HIV/ARC	Pollo	STD	
Bone Fracture	Epilepsy	Kidney Trouble	Prostate Trouble	Thyroid Trouble	

Type of Cancer:

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Patient Medical History, continued

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Social History:

Alcohol Consumption? ○ Yes ○ No

Coffee Consumption? ○ Yes ○ No

Soda Consumption? ○ Yes ○ No

Water Consumption: ________ ounces/day

Sleep Amount? ________ hours/night

Recreational Drug Use? ○ Yes ○ No

Healthy Eating Rank? **(0-poor, 10 excellent)**

Exercise Frequency: ________ hours/day

Major Stressors:

Things to Improve:

Other Health Goals:

Smoking History:

Currently Smoke? ○ Yes ○ No

Years Smoked? ________ years

Packs Per Day? ________

Comments on Smoking:

Comments:

Patient Name (Printed): ________________________

Patient Signature: ______________________________ **Date:** ____________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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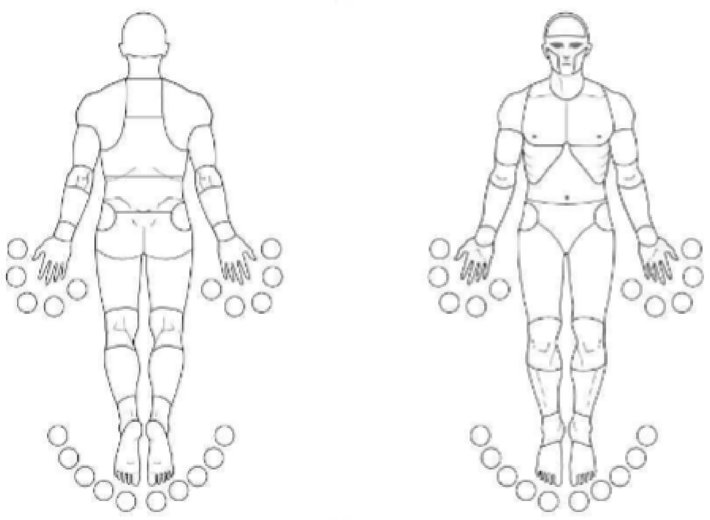
Current Complaints

-

Please indicate the current complaints you are experiencing by marking the image below and providing details using the sections below.



Pain / Symptom Intensity:	**0 (None) 1 2 3 4 5 6 7 8 9 10 (Excruciating)**
Mechanism of Injury:	
When and How Did the Condition Occur?	
Frequency (How often?)	**Infrequent < 25%** **Occasional 25%-50%** **Frequent 50% - 75%** **Constant > 75%**
Duration (of pain)?	________ days, weeks, months, years over the past ________ days, weeks, months, year(s)

When does the pain tend to be at it worst?

Morning **Throughout the day** **End of Day** **Night** **During/After strenuous activities**

Would you describe the pain as radiating/shooting? If so, where?

○ **Yes** ○ **No** *Where?*____

The symptoms are described as (circle all that apply):

Dull
Tingling
Sharp
Stabbing
Throbbing
Cramping
Burning
Numbness
Deep
Radiating
Aching

What makes it worse? (circle all that apply):

Sitting
Sleeping
Looking Up
Typing
Standing
Sneezing
Looking Down
Scooping
Walking
Coughing
Movement
House Chores
Bending
Straining
Rest
Exercise
Stooping
Reaching
Lying Supine (up)
Lying Prone (down)
Lifting
Twisting
Driving
Stair Stepping

What makes it better? (circle all that apply):

Sitting
No Movement
Ibuprophen
Standing
Movement
Medication
Lying
Heat
Rest
Knees bent up
Ice
Stretching/Exercise
Support
Topical Analgesic
Adjustments

Comments:

Patient's Signature ________________________________

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Acknowledgement Form

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Victory Chiropractic "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Victory Chiropractic's Notice of Privacy Practices prior to signing this document. Victory Chiropractic's Notice of Privavy Practices has benn provided to me. The Notice of Privavy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payments of my bills, or in the performance of health care operations of Victory Chiropractic. The Notice of Privacy Practices for Victory Chiropractic is also provided upon request at the front desk of this practice and on Victory Chripractic's website (www.victory_chiro.com). This Notice of Privacy also describes my rights and Victory CHiropractic's duties with respect to my protected health information.

Victory Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Victory Chiropractic's website, calling the office, requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

Consent to Treatment

Chiropractic examination (history, examination, and x-rays) and therapeutic procedures (including but not limited to spinal and/or extremity adjustments, heat/cold application, mechanical traction, acupuncture, manual muscle therapy, graston technique, kinesio-tape, electrical muscle stimulation, therapeutic ultrasound, and therapeutic exercises) are considered safe and effective methods of care. However, any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of Victory Chiropractic to inform the patients about them. Additional diagnostics such as advanced imaging, labratory tests and/or outside medical referral may also be ordered as needed.

Complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruises, and temporary worsening of symptoms. More serious complications such as fractures and strokes are extremely rare. Your treating doctor, upon request, can explain additional information on side effects and complications.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarentee or warranty for a specific cure or result. It is understand that this authorization is given in advance of any specific diagnosis or treatment being required.

I consent to the provisions of care. I understand that this care may include treatment, special tests, exams, evaluations, and rehabilitation. I understand that no guarentees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.

I understand and agree that others may assist in providing care. This may include any staff members or interns of Victory Chiropractic.

*This authorization shall remain effective unless revoked in writing by the undersigned.

Patient/Guardian Name (printed):____________________________________

Signature:_____________________________________

Date:_________________________

Staff Member Signature:__________________________ **Date:**_________________