WELCOME TO OUR OFFICE

__/__/__
TODAY'S DATE

1. PATIENT INFORMATION

(PLEASE PRINT)

NAME_____
FIRST LAST MI

ADDRESS_____

_____
CITY STATE ZIP

SEX ☐M ☐F DATE OF BIRTH__/__/__AGE__
☐SINGLE ☐MARRIED ☐WIDOW
☐SEPARATED ☐DIVORCED
OCCUPATION_____☐FT ☐PT
EMPLOYER_____
EMPLOYER ADDRESS_____
_____

SPOUSE'S NAME_____
DATE OF BIRTH __/__/__
ARE YOU THE PARENT OR LEGAL GUARDIAN OF THE PATIENT?
☐YES YOUR NAME_____
☐NO RELATIONSHIP TO PATIENT_____
_____

2. ACCIDENT INFORMATION

IS YOUR CONDITION DUE TO AN ACCIDENT? ☐YES ☐NO
TYPE OF ACCIDENT:
☐AUTO ☐WORK ☐HOME ☐OTHER

TO WHOM HAVE YOU MADE A REPORT OF THIS ACCIDENT ?
☐AUTO INSURANCE ☐EMPLOYER
☐WORK COMP ☐OTHER

ATTORNEY_____
PHONE _____

AUTOMOBILE INSURANCE

YOUR INSURANCE COMPANY
_____
I.D. NUMBER_____
CLAIM NUMBER_____
PHONE NUMBER_____
SUBSCRIBER'S NAME_____
DATE OF BIRTH___/___/___
PHONE_____

3. PHONE NUMBERS

HOME _____WORK _____ CELL _____
☐ CHECK BOX IF OK TO LEAVE MESSAGES ON YOUR CELL OR TEXT WITH HIPAA PROTECTED INFORMATION

E-MAIL _____
☐ CHECK BOX IF OK TO CONTACT YOU VIA E-MAIL WITH HIPAA PROTECTED INFORMATION

WHOM SHOULD WE CONTACT IN CASE OF EMERGENCY?
NAME _____RELATIONSHIP _____
CELL _____WORK _____

4. PATIENT CONDITION – YOUR MAIN COMPLAINT...

REASON FOR TODAY'S VISIT_____ DATE STARTED__/__/__
DO YOU KNOW WHAT MAY HAVE CAUSED THIS? _____
IS YOUR PAIN/DISCOMFORT: ☐DULL ☐SHARP ☐BURNING ☐TINGLING
☐THROBBING ☐NUMBNESS ☐STABBING

AND IS IT? ☐MILD ☐MODERATE ☐SEVERE PAIN SCALE: MILD 1 2 3 4 5 6 7 8 9 10 SEVERE

HOW OFTEN DO YOU SUFFER FROM THIS? ☐DAILY ☐__X PER WEEK ☐__X PER MONTH ☐__X PER YEAR

HOW LONG DOES IT LAST? _____IS IT ☐INTERMITTENT ☐FREQUENT ☐CONSTANT
WHAT MAKES IT BETTER? _____WHAT MAKES IT WORSE? _____
DOES IT INTERFERE WITH: ☐WORK ☐SLEEP ☐DAILY ROUTINE ☐RECREATION
☐WALKING ☐BENDING ☐STANDING ☐SITTING
WHAT HAVE YOU TRIED TO RELIEVE YOUR SYMPTOMS? _____

6. PAST HEALTH HISTORY

PATIENT NAME:

Do you have any of the following? **Please check YES or NO for each condition.**

Relative Contraindications:			Absolute Contraindications:		
Articular Hypermobility Disease	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Severe Demineralization of Bone	☐Yes	☐No	Ankylosing Spondylitis	☐Yes	☐No
Benign Bone Tumor (Spine)	☐Yes	☐No	Fracture(s)_____	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No	Dislocation(s)_____	☐Yes	☐No
Are you taking Anticoagulants Therapy	☐Yes	☐No	Unstable OS Odontoedum	☐Yes	☐No
Radiculopathy with Progressive Neurological Signs,			Malignancies	☐Yes	☐No
Radiating Pain, Numbness or Weakness into:			Infection of bones or joints of the vertebral column	☐Yes	☐No
Upper Extremities	☐Yes	☐No	Myelopathy	☐Yes	☐No
Lower Extremities	☐Yes	☐No	Cauda Equina Syndrome	☐Yes	☐No
Do you have a Pacemaker or any other Electrical Implant	☐Yes	☐No	Major Artery Aneurysm	☐Yes	☐No

Previous Major Illnesses and Injuries_____

Operations, Hospitalizations, Surgeries_____

Check off Conditions that You are Currently Taking Medications for: ☐None

High Blood Pressure_____ **Cholesterol**_____ **Pain**_____ **Arthritis**_____

Depression_____ **Anxiety**_____ **ADD/ADHD**_____ **Insulin**_____

Other_____

Allergies

FAMILY HISTORY -**Immediate Family Members (Father, Mother, Brother, Sister)**

Health Status of family Members:_____

Are there any family members that suffer from:

☐Stroke ☐ Heart Disease ☐Cancer ☐Tumor ☐Degenerative Disc Disease ☐Arthritis ☐Osteoporosis

☐Other_____

If any of the above items are checked, then whom in your family suffers?_____

_____

Are there any diseases that are "hereditary" or seem to run in your family?

SOCIAL HISTORY - **Please answer the following:**

Please tell the Doctor about your activities:

Exercise:	Work/School:	Habits: ☐None		Education:
☐None	☐Sitting	☐Smoking – Packs Per Day____	☐None Drugs _____ ☐None	☐High School
☐Occasional	☐Standing	☐Alcohol –Times Per Week_____	☐None	☐Some College
☐Daily	☐Light Labor	☐Caffeine: Coffee, Tea, Sodas…Cups Per Day_____	☐None	☐College Grad
☐Weekly	☐Heavy Labor	Hobbies_____	☐None	☐Post Grad
☐Other	☐Computer			

I certify the information on these forms are true to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic and therapeutic care for my condition if I am accepted as a patient

Patient Signature_____ **Date** ___/___/___

Doctors Signature_____ **Date** ___/___/___

SYMPTOM(S) QUESTIONNAIRE

Patient Name _____ ☐ Initial Visit ☐ Subsequent Visit

Please tell us about your symptoms: _____

_____

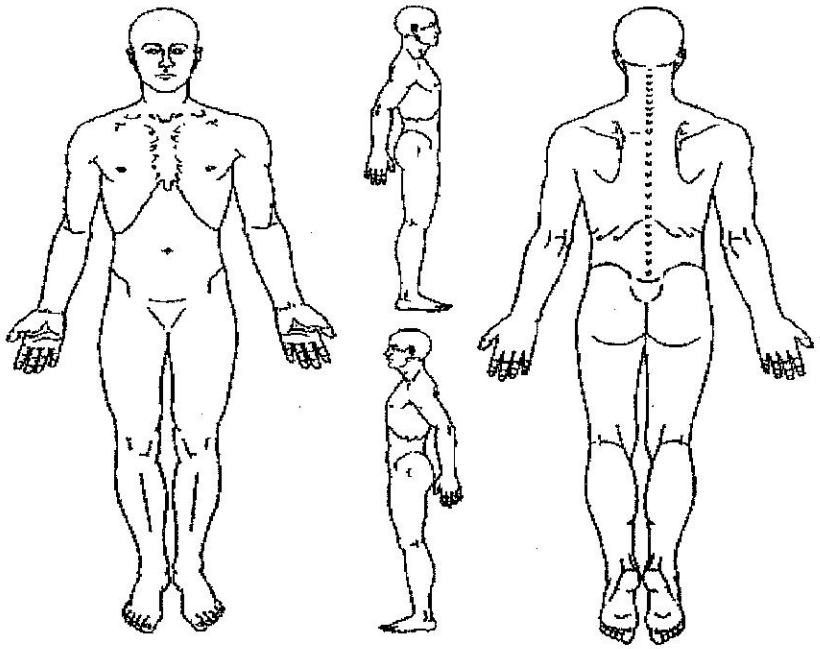
My pain / symptom(s) are getting: Better Worse About the same Other

Please use the key to mark the diagram

Pain / Discomfort Scale: (please Circle) Least 0 1 2 3 4 5 6 7 8 9 10+ Worst

A = Ache B = Burning N = Numbness S = Stiff SR = Sore

T = Tingle P = Pain W = Weak P&N = Pins & Needles



Please tell us how your symptoms are affecting your activities

HOME	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sleeping	☐	☐	☐	☐
Self Care	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

WORK	No Effect	Mild Effect	Moderate Effect	Severe Effect
Concentration	☐	☐	☐	☐
Duties, Activities	☐	☐	☐	☐
Mood	☐	☐	☐	☐
Travel	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

OTHER ACTIVITIES	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sit, Stand, Walk	☐	☐	☐	☐
Raising from Chair	☐	☐	☐	☐
Bend, Lift, Twist	☐	☐	☐	☐
Turn Head	☐	☐	☐	☐
Hobbies, Exercise, Sports	☐	☐	☐	☐
Enjoyment	☐	☐	☐	☐

Patient Signature _____ Date ____/____/____

Doctor Signature _____ Date ____/____/____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
translated by

_____
date

_____
date

Cove Freedom Chiropractic

211 Liberty Bell Lane, Suite 111
Copperas Cove, Tx 76522

Clinic Policies

The following is an explanation of our clinic policies. We believe that a clear definition will allow us all to concentrate on the most important issue. Regaining and maintaining your health.

No Charge Consultation
Cove Freedom Chiropractic Clinic will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problems. There is no charge or obligation in connection with this appointment.

New Patient Care Services
We require the payment in full on the first visit unless prior arrangements are made. Then the balance of these charges may be made in payments over the course of your treatment schedule. Properly documented auto accident claims are not required to pay at this time if appropriate forms and liens are signed.

Established Patient Care
Patients under care are required to make regular payments on all unpaid balances except for properly documented auto injury claims. Payments need to be made according to prior arrangements. We reserve the right to charge finance charges and late fees to any account that is not paid in a timely manner.

Appointments
In order to better serve our patients, we ask that you call if you need to reschedule your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could have been used to help someone else. Please help us help others.

Questions and Answers
Your questions about any aspect of your care and account are invited. Please feel free to ask your doctors or staff members. We will make every effort to answer your inquiries.

Payments
Payments for office visits are due the same day as your office visits unless other documented arrangements have been made, such as our Cove Freedom Finance plan, Special Consideration payment Plan, or our Cove Freedom Membership plan.

I have read the Cove Freedom Chiropractic Clinic Policies and will honor them.

Patient's Signature_____ **Date**_____/_____/_____