CHERRY LANE CHIROPRACTIC, INC.
CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient.
Please fill in all portions of the form. If you need any help, please ask the receptionist.

IS VISIT ACCIDENT RELATED? ______ YES ______ NO
(If YES please notify the receptionist for accident forms)

DATE ________________________ Who referred you to our clinic? ________________________

NAME ____

ADDRESS ________________________ CITY ______________ STATE _____ ZIP ________

CELL PHONE ( )____________________ HOME PHONE ( )____________________ [H W)

E-MAIL ADDRESS ________________________________

AGE _________ BIRTH DATE ________________________ MARITAL STATUS ____ SEX ____ #

OF CHILDREN ____________________

OCCUPATION ____________________ EMPLOYER ________________________

____

SOCIAL SECURITY # ____________________ NAME OF SPOUSE ________________________

SPOUSE'S OCCUPATION ________________________

SPOUSE'S EMPLOYER ____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU ________________________________

ADDRESS ____ PHONE ____________________

PRESENT COMPLAINT - Briefly describe symptoms: ________________________________

____

When did this condition begin? ____

List other doctors you have seen for this condition ________________________________

List any operations you have had and when ____

Have you ever seen a chiropractor? _____ Yes _____ No

Doctor's name & approximate date of last visit ________________________________

Have you been treated by a physician for any health condition in the last year? _____ Yes _____ No

Date of last physical exam ____

Are you taking any medication? ______ Yes ______ No If yes, please list ________________________________

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and the possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Poor/Excessive Appetite
- ☐ Excessive thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis
- ☐ Bladder Trouble
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffy Nose
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

FEMALES ONLY:

When was your last period?

____

Are you pregnant?

☐ Yes ☐ No ☐ Maybe

Front View　　Back View

R　L　L　R

Please outline on the diagram the area of your discomfort.

Why chiropractic? People go to the chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Comprehensive Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care ☐ Doctor to select type of care appropriate for my condition

I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of manipulations, therapy, and such additional procedures as are considered therapeutically necessary in the course of said treatment. I hereby certify that I have read and fully understand this Authorization for Chiropractic Treatment, the reason that the above named treatment is considered necessary, and its advantages and/or possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the doctor. It is understood and agreed the amount paid the doctor for x-rays is for examination only. X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

Patient's Signature X ________________________________ Date ______________

Guardian or Spouse
Signature Authorizing Care X ________________________________ Date ______________

CHERRY LANE CHIROPRACTIC, INC.
2603 Cherry Lane
Fort Worth, TX 76116
817-560-1625

Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office.

This notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to CHERRY LANE CHIROPRACTIC, INC. to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to CHERRY LANE CHIROPRACTIC, INC. to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care, treatment alternatives or other health related information.
- If CHERRY LANE CHIROPRACTIC, INC. contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give CHERRY LANE CHIROPRACTIC, INC. permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.
- By signing this form you are giving CHERRY LANE CHIROPRACTIC, INC. permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at CHERRY LANE CHIROPRACTIC, INC. more efficient and productive as well as to enhance your access to quality Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at the CHERRY LANE CHIROPRACTIC, INC. plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the CHERRY LANE CHIROPRACTIC, INC. The written notice must contain the following information:

- Your name, Social Security number, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature

The revocation is not effective until it is received by CHERRY LANE CHIROPRACTIC, INC.

This AUTHORIZATION is requested by CHERRY LANE CHIROPRACTIC, INC. for its own use / disclosure

CHERRY LANE CHIROPRACTIC, INC.
2603 Cherry Lane
Fort Worth, TX 76116
817-560-1625

This AUTHORIZATION is requested by CHERRY LANE CHIROPRACTIC, INC. for its own use / disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, CHERRY LANE CHIROPRACTIC, INC. will provide care , however, it will not be possible for CHERRY LANE CHIROPRACTIC, INC. to file third party billing on my behalf and I will be responsible for: 1) payment in full at the time services are provided to me 2) scheduling my own appointments since CHERRY LANE CHIROPRACTIC, INC. will be unable to contact me 3) all contact with CHERRY LANE CHIROPRACTIC, INC. regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, with boundaries, the Protected Health Information to be used / disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: ___________________________________ D.O.B.: _______ / _______ / _______

My Name (Print): ____

My Signature: ____

Today's Date: _______ / _______ / _______

Name of Personal Representative (If someone other than yourself is designated to act on your behalf).Allow my medical information/condition to be disclosed with the following individual.

Name (Print): ____

Signature of Personal Representative: ____

Description of Representative's Authority To Act On your Behalf: ______________________________

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