Pain Drawing

*Name*_____ *Date* _____

*Date of Birth*_____

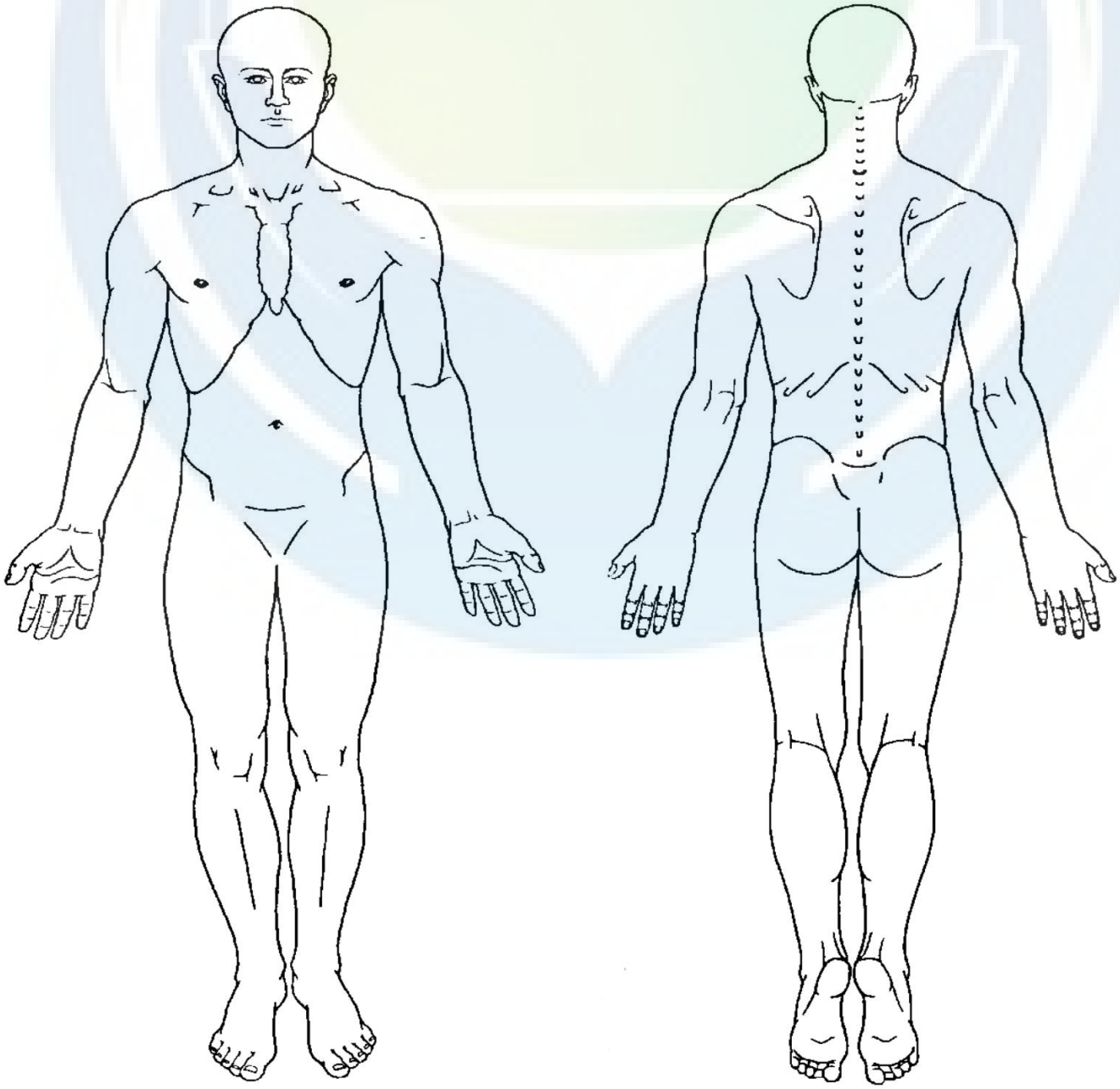
Tell us where it hurts

Please read carefully

Mark the areas on your body where you feel your pain. Please include ALL affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where from it starts to where it stops. PLEASE extend the arrow as far as the pain travels.

Please Use the appropriate symbols below to describe the rest of your pain

Ache **Numbness - - - -** **Pins & Needles ooooo**
Burning xxxxxx **Stabbing //////** **Throbbing**



Patient Name_____ Date of Birth _____
SS#/SIN _____ Male ____ Female ____
Patient E-Mail_____ Cell Phone _____
Home Phone _____
Address _____ City _____ State_____ Zip_____
Patient Employer _____
Circle Appropriate Minor Single Married Divorced Widowed Separated

Who should we thank for referring you? How did you hear about us?_____

***Spouse / Guardian** (If you are a Single, Divorced orWidowed leave this blank)*

Spouse/ Parent Guardian Name _____ Relationship _____
Spouse/ Parent Guardian Employer _____
Cell Phone Number _____ Home Phone _____

***Emergency Contact** Person to contact in case of an emergency*
Name _____ Phone Number _____
Relationship _____

Medication List

If you need more room you may use the back of this page for any section

	Medication Name	Dose	How Much	Reason you take this	When do you take: Morning	Lunch	Evening	Bedtime	As Needed
Ex	Tramadol	30mg	1 pill	Back Pain	X			X	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									

	Over the counter Medications (store bought) or (Vitamines)	Dose	How Much	Reason you take this	Morning	Lunch	Evening	Bedtime	As Needed
EX	Vitamin D3	125mcg	2 pills	Vitamin D Defency	x				
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Allergies	Reaction	Epi Pen ?

Name _____ Date _____

Personal History

Check all conditions that apply

General

- ☐ Fatigue & tiredness
- ☐ Weakness
- ☐ Chills
- ☐ Fever
- ☐ Night sweat
- ☐ Appetite change
- ☐ Lived in foreign country
- ☐ Unexplained weight Loss / Gain
- ☐ Generalized pain
- ☐ Unable to tolerate heat
- ☐ Unable to tolerate cold
- ☐ Sedentary lifestyle
- ☐ Active lifestyle
- ☐ Other _____

Neurological

- ☐ Fainting spells
- ☐ Seizures
- ☐ Paralysis
- ☐ Dizziness
- ☐ Tremor
- ☐ Chronic headaches
- ☐ Poor balance
- ☐ Fractured back or neck
- ☐ Numbness of face / arm / leg
- ☐ Peripheral neuropathy
- ☐ Stroke or Mini – stroke
- ☐ Other _____

Psychiatric

- ☐ Depression
- ☐ Anxiety (abnormal)
- ☐ Panic attacks
- ☐ Alzheimer's
- ☐ Confusion (abnormal)
- ☐ Hospitalized for nervousness
- ☐ Substance abuse
- ☐ Anorexia
- ☐ Other _____

Respiratory

- ☐ Chronic obstructive disease
- ☐ Wheezing
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Shortness of breath
- ☐ TB
- ☐ Lung Cancer
- ☐ Emphysema
- ☐ Chronic bronchitis
- ☐ Pneumonia
- ☐ Fluid in lungs
- ☐ Need to sleep sitting up
- ☐ Other _____

Cardiac

- ☐ Angina (chest pain)
- ☐ Rapid heartbeat
- ☐ Past heart attacks
- ☐ Heart murmur
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Aortic aneurysm
- ☐ Other heart problem
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Other_____

Vascular

- ☐ Leg pain while walking
- ☐ Pain in legs while at rest
- ☐ Blood clots in legs
- ☐ Cold feet or hands
- ☐ Amputation of toes
- ☐ Amputation of feet or legs
- ☐ Peripheral vascular disease
- ☐ Ulcers of lower legs
- ☐ Varicose veins
- ☐ Aneurysm of arteries
- ☐ Other _____

Gastrointestinal

- ☐ Diarrhea/Constipation
- ☐ Stool changes
- ☐ Bowel habits changes
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Colon polyps
- ☐ Cramps/ pains
- ☐ Cancer of the stomach or bowel
- ☐ Diverticulitis
- ☐ Other _____

Genitourinary

- ☐ Hesitancy / urgency of urine
- ☐ Need to urinate often at night
- ☐ Loss of bladder control
- ☐ Difficult urination
- ☐ Renal failure
- ☐ Impotence
- ☐ Current Dialysis
- ☐ Renal transplant
- ☐ Prostate enlargement
- ☐ Cancer of bladder/ kidneys
- ☐ Other _____

Blood & Lymph System

- ☐ Anemia
- ☐ Blood disease
- ☐ Transfusions
- ☐ Leukemia
- ☐ Bone marrow test
- ☐ Long term Coumadin use
- ☐ Blood clotting problems
- ☐ Other _____

Eyes, Ears, Nose & Throat

- ☐ Pain
- ☐ Hearing loss
- ☐ Polyps
- ☐ Vertigo
- ☐ Ringing in ears (tinnitus)
- ☐ Sinus infections
- ☐ Deafness
- ☐ Other _____

Musculoskeletal

- ☐ Arthritis
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Leg cramps
- ☐ Other _____

Skin

- ☐ Rashes
- ☐ Tumors
- ☐ Sensitivity to sunlight
- ☐ Malignant melanoma
- ☐ Squamous cell carcinoma
- ☐ Basal cell carcinoma
- ☐ Easy bruising
- ☐ Fungal infections
- ☐ Non-healing sores
- ☐ Excessive rough or dry skin
- ☐ Other _____

Endocrine

- ☐ Thyroid Problems
- ☐ Diabetes- Type 1
- ☐ Diabetes- Type 2

X-RAY CONSENT FORM

Patien: _____ Date: _____

Daring your examination, the doctor may feel that x-rays will be needed in order to diagnosis your condition. We would like to make you aware that x-rays may be required, in order, to administer treatment
In order to perform x-rays on any patient our office requires the patients consent for such tests to be performed.
Please choose one:

_____ I understand that my doctor may need x–rays in order to diagnosis my condition and I give permission of all needed diagnostic tests.

_____I understand that my condition may require my doctor to take X rays to further my diagnosis. I choose NOT to have X rays and release my doctor and this office from all liabilities related to this.

Signature:_____ Date: _____

FEMALES ONLY

I understand that if I am pregnant and have x-rays taken which will expose my lower torso to radiation, it is possible to injure the fetus.

I have been advised that the ten (I 0) days following onset of a menstrual period are generally considered to be-safe for x-ray exam.

With those factors in mind, I am advising my doctor that	
I am pregnant	___Yes ___No
I could be pregnant	___Yes ___No
My menstrual period is late	___Yes ___No
I have an IUD	___Yes ___No
I have had a tubal ligation	___Yes ___No
I have had a hysterectomy	___Yes ___No
I have irregular menstrual periods	___Yes ___No
last menstrual period began	_____
Begun menopause	___Yes ___No

With full understanding of the above, and believing that I am not currently at risk, I wish to have an x-ray examination performed today if requested by my doctor.

Signature: _____ Date: _____

Complete Health Medical Center

905 Ferris Ave
Waxahachie, Texas 75165

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grant and conveys, to Complete Health Medical Center and any and all providers associated with them, a lien and assignment of any and all claims, causes of action, and right to any proceeds and/or benefits, including any Personal Injury Protection proceeds and/or that benefit the patient may have against any other person, entity, and/or insurance company for reimbursement and/or payment of the medical charges incurred with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster for purposes of my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever assist in the prosecution of such claims for benefits upon request

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Complete Health Medical Center 905 Ferris Avenue, Waxahachie TX 75165

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Complete Health Medical Center, and to send any and all check to 905 Ferris Avenue, Waxahachie Texas 75165.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period. If during my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of Patient/or Responsible Parties:

_____ _____
Patient and/or Responsible Party Date

_____ _____
Witness Date

COMPLETE HEALTH MEDICAL CENTER

905 Ferris Ave
Waxahachie, Texas 75165

Patient Name: _____ DOB _____

Release of Information I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse_____Phone:_____
Child(ren)_____Phone:_____
Other_____ Phone:_____ _
Other _____Phone: _____

____ Information is not to be released to anyone.

[ ] I UNDERSTAND THAT THIS RELEASE WILL REMAIN IN EFFECT UNTIL OTHERWISE STATED BY ME IN WRITING.

Notice of Privacy Practices A copy of Complete Health Medical Center (CHMC) Notice of Privacy Practices (NPP) is available to you if requested.

Please check one of the following boxes below:

[ ] I have been provided a copy of CHMC's NPP today, upon my request (please see our receptionist and he/she will promptly provide you with a copy)
[ ] I will not take a copy of CHMC's NPP today but am aware that it is posted clearly at the front desk and online for review, and is available to me if I request a copy in the future.

Messages Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____ It is best to reach me: (day)_____ between (time)_____ Is it okay to email or send a text message as a reminder for any future appointments? Yes:____ No: _____

Email: _____

Signature: _____ Date: _____

Complete Health Medical Center

Patient Name: _____ Date of birth: _____

1. **General Consent** – I consent to allowing the applicable Complete Health Medical Center, PLLC affiliated facilities listed below ("Facility") to provide me with necessary medical service, evaluation, diagnosis, treatment, and care (collectively, "care"). My consent includes any examination, imaging, laboratory test, (including, but not limited to, test to determine HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS), medications, medical treatment, and/or other services rendered by physicians, advance practice professionals, technical assistants, their associates and other healthcare providers, including nurses and other Facility staff (collectively, "providers") which are advisable during the course of my evaluation, diagnosis, and treatment.
2. **Chiropractic Consent** – I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures, and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.
3. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:
   - Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.
   - Therapeutic modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
4. **Telemedicine** – I consent to the Facility providing me with necessary care through telemedicine / telehealth, or through the use of electronic communications, with providers who are located at a different site(s) ("off-site providers"). I agree and understand that I may be billed for any out-of-pocket costs such as co-pay, deductible, or coinsurance based on my health or insurance plans.
5. **Teaching Location** – I agree and understand that the Facility may be a teaching facility and residents, fellows, and students from various teaching programs may participate in my care. I may ask for information on the specific affiliation(s) of any of my providers. I consent to allow residents, fellows, students, and authorized individuals to participate and observe the care provided to me as determined by my providers and as permitted by facility policy.
6. **State Reporting Requirements** – I agree and understand that the Facility or provider is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the sate health department or the Centers for Disease Control and Prevention. Also, I understand that the Facility is required by law to report certain activities including abuse or neglect.
7. **Personal Property** – I agree and understand that I am responsible for my personal property. I understand that any and all valuables or other articles of personal property should be placed in the care of a family member or other authorized representatives. The Facility is not responsible for the safekeeping of these items.
8. **Warranty and Guarantee** – I agree and understand that the practice of medicine, as well as chiropractic, is not an exact science and acknowledge that no warranties or guarantees have been made about the results of my care rendered by the Facility or providers.

_____ _____

Patient Signature or Legally Authorized Representative Date

_____

Relationship to Patient