# coppell wellness center

**TODAY'S DATE** _____ **FILE NO.** _____

## PATIENT DATA

**NAME** _____ (LAST) _____ (FIRST) _____ (MIDDLE)

**WHAT DO YOU PREFER TO BE CALLED** _____ **REFERRAL SOURCE** _____

**HOME ADDRESS** _____ (STREET) _____ (CITY / STATE) _____ (ZIP)

**HOME PHONE** ( ) - **DATE OF BIRTH** _____

**CELL PHONE** ( ) - ☐ **MALE** ☐ **FEMALE**

**E-MAIL ADDRESS** _____

**ARE YOU OVER 18 YEARS OF AGE?** ☐ **YES** ☐ **NO** (PARENTAL AUTHORIZATION REQUIRED SEE BACK OF FORM)

**MARITAL STATUS** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED** ☐ **WIDOWED**

**EMPLOYED BY** _____ **OCCUPATION** _____

**BUSINESS ADDRESS** _____ **HOW LONG?** _____

**SPOUSE'S NAME** _____ **OCCUPATION** _____

**EMPLOYED BY** _____ **WORK PHONE** _____

**EMERGENCY CONTACT IF OTHER THAN SPOUSE** _____ **PHONE** _____

## HEALTH HISTORY (*HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS*)

| YES | NO | CONDITION | YES | NO | CONDITION | YES | NO | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ALCOHOL / DRUG ABUSE | ☐ | ☐ | EMPHYSEMA / GLAUCOMA | ☐ | ☐ | POLIO |
| ☐ | ☐ | ANEMIA | ☐ | ☐ | FAINTING / SEIZURES / EPILEPSY | ☐ | ☐ | PSYCHIATRIC PROBLEMS |
| ☐ | ☐ | ARTHRITIS | ☐ | ☐ | FREQUENT NECK PAIN | ☐ | ☐ | RHEUMATIC FEVER |
| ☐ | ☐ | ARTIFICIAL BONES / JOINTS | ☐ | ☐ | HEART ATTACK / STROKE | ☐ | ☐ | SEVERE / FREQUENT HEADACHES |
| ☐ | ☐ | ARTIFICIAL VALVE | ☐ | ☐ | HEART MURMUR | ☐ | ☐ | SHINGLES |
| ☐ | ☐ | ASTHMA | ☐ | ☐ | HEART SURGERY / PACEMAKER | ☐ | ☐ | SINUS PROBLEMS |
| ☐ | ☐ | CANCER | ☐ | ☐ | HEMORRHOIDS | ☐ | ☐ | TRANSMANDIBLE JOINT DISEASE |
| ☐ | ☐ | CARPAL TUNNEL | ☐ | ☐ | HEPATITIS | ☐ | ☐ | ULCERATIVE COLITIS |
| ☐ | ☐ | CHEMOTHERAPY | ☐ | ☐ | HIGH / LOW BLOOD PRESSURE | ☐ | ☐ | ULCERS / COLITIS |
| ☐ | ☐ | CONGENITAL HEART DEFECT | ☐ | ☐ | INTESTINAL PERFORATION | ☐ | ☐ | VASCULAR ANEURISM |
| ☐ | ☐ | CROHN'S DISEASE | ☐ | ☐ | KIDNEY PROBLEMS | ☐ | ☐ | VENEREAL DISEASE |
| ☐ | ☐ | DIABETES / TUBERCULOSIS | ☐ | ☐ | LIVER PROBLEMS | **OTHER** | | _____ |
| ☐ | ☐ | DIALYSIS TREATMENTS | ☐ | ☐ | LOWER BACK PROBLEMS | | | _____ |
| ☐ | ☐ | DIFFICULTY BREATHING | ☐ | ☐ | MITRAL VALVE PROLAPSE | | | |
| ☐ | ☐ | DIGESTIVE DISORDERS | ☐ | ☐ | MULTIPLE SCLEROSIS | | | |
| ☐ | ☐ | DIVERTICULITIS | ☐ | ☐ | MUSCULAR DYSTROPHY | | | |
| ☐ | ☐ | DIZZINESS/VERTIGO | ☐ | ☐ | NEURITIS | | | |

**WOMEN ONLY**

ARE YOU PREGNANT? ☐ YES ☐ NO

ARE YOU NURSING? ☐ YES ☐ NO

SMOKING ☐ YES ☐ NO IF "YES" HOW MUCH ? _____

ALCOHOL ☐ YES ☐ NO IF "YES" HOW MUCH ? _____

*(Please turn page over to complete back of form)*

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### PURPOSE OF VISIT

**REASON FOR THIS VISIT:** ☐ **WORK INJURY/ILLNESS** ☐ **SPORTS INJURY** ☐ **AUTO ACCIDENT** ☐ **OTHER**

**DESCRIBE:** _____

**DATE OF INJURY** _____ **NUMBER OF DAYS MISSED FROM WORK?** _____

**HAVE YOU BEEN TREATED FOR THIS INJURY BEFORE?** ☐ **YES** ☐ **NO** **IF "YES", PLEASE EXPLAIN:**

_____

HAVE YOU HAD X-RAYS TAKEN FOR THE AREA REQUIRING TREATMENT: ☐ NO ☐ YES

IF "YES", WHEN AND WHAT AREAS WERE X-RAYED? _____

### INFORMED CONSENT

To ensure you are fully informed regarding your care; to that purpose we are providing the following information. We also invite and encourage you to discuss with us any questions regarding your treatment and/or our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- Our practice objective is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. A vertebral subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which cause an alteration of the nerve function and interference to the transmission of mental impulses.
- Various modes of physical therapy and diagnostics may be utilized by the doctor in order to determine the best course of treatment. Care and treatment may be delivered by our licensed doctors of chiropractic and /or the associates working at the facility.
- I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to dislocations, strains or disk impairment. I understand the doctor cannot anticipate nor explain all risks, and I wish to rely on the doctor to exercise judgment during the course of the procedure based on known facts and my best interest.
- Office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If an account is submitted for insurance payment and payment is discounted or denied, I understand I am fully responsible for all outstanding charges. If account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting on my account. I also understand that if I suspend or terminate care and treatment, any fees for services will be immediately due and payable.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand that if I do not give at least 24-hours notice when canceling an appointment, I may be responsible for a cancellation charge, not to exceed $35, to cover any lost costs and wages for my therapist.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I have read or have had read to me the above consent and I accept care on this basis.

**SIGNATURE** _____ **DATE** _____

### PARENT OR GUARDIAN AUTHORIZATION: *[ONLY IF PATIENT IS UNDER 18 YEARS OF AGE]*

- I, _____ being the parent/legal guardian of _____
  [PLEASE PRINT YOUR NAME] [PLEASE PRINT NAME OF CHILD OR WARD]
  have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**SIGNATURE** _____ **DATE** _____