BACK PAIN & SCIATICA CENTER OF TEXAS
REGENERATIVE PAIN SOLUTIONS

3401 W. Davis St. Ste A2
Conroe, TX 77304

936-494-1222
www.backpaincenteroftexas.com

Name _____ **Cell Phone** _____

Address _____ **Home Phone** _____

City, State, Zip _____ **Birthdate** _____

Male / Female Age _____ **Height** _____**Weight** _____ **SS#** _____

Email_____ **Occupation** _____ **Employer** _____

Emergency Contact _____ **Phone Number** _____

Marital Status: Single ___ **Married** ___ **Spouse Name** _____**No# of Children** _____

Responsible Party: Same as Above _____ **Different** _____ **(complete below information)**

Individual Responsible for this Account _____ **Relationship to Patient** _____
Address _____ **Home Phone** _____
E-Mail _____ **Cell Phone** _____

Many people are referred to our office by a family member or friend. Who can we thank for referring you to our office?

__ Friend / Family: _____
__ Internet Search: Google _____ Yahoo _____ Yelp _____ Other (please specify)_____
__ Facebook
__ Newspaper
__ Other: _____

Please circle or list any health symptoms or health complaints you are currently experiencing:

Neck Pain - Left / Right	Arm Pain/Numbness - Left / Right	Asthma	Allergies: _____
Mid-Back Pain - Left / Right	Leg Pain/Numbness - Left / Right	Cancer	_____
Lower Back Pain - Left / Right	Headaches/Migraines	Constipation	Other: _____
Knee Pain Left / Right	Diabetes I/II	Heartburn	_____
Shoulder Pain - Left / Right	Neuropathy	High Blood Pressure	_____

Past Medical History

Have you ever had the following: (circle "yes" or "no" - leave blank if you are uncertain)

Measles ..... NO YES	Anemia ..... NO YES	Back Trouble ..... NO YES	Blood or Plasma
Mumps ..... NO YES	Bladder Infection ... NO YES	High Blood Pressure NO YES	Transfusion ... NO YES
Chicken Pox ..... NO YES	Epilepsy ..... NO YES	Low Blood Pressure NO YES	Mitral Valve
Whooping Cough NO YES	Migraine Headaches NO YES	Hemorrhoids ..... NO YES	Prolepses ..... NO YES
Scarlet Fever ..... NO YES	Tuberculosis ..... NO YES	Asthma ..... NO YES	Date of last chest x-ray
Diptheria ..... NO YES	Diabetes ..... NO YES	Hives of Eczema ..... NO YES	_____
Small Pox ..... NO YES	Cancer ..... NO YES	HIV/AIDS ..... NO YES	
Pneumonia ..... NO YES	Polio ..... NO YES	Hepatitis ..... NO YES	Any other disease: (please list)
Rheumatic Fever NO YES	Glaucoma ..... NO YES	Bronchitis ..... NO YES	
Arthritis ..... NO YES	Hernia ..... NO YES	Infectious Mono ..... NO YES	_____
Venereal Disease NO YES	Ulcer ..... NO YES	Stroke ..... NO YES	
Kidney Disease ... NO YES	Thyroid Disease ..... NO YES	Bleeding Tendency .. NO YES	_____

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Previous Hospitalizations/Surgeries/Serious Illnesses	**When?**	**Hospital, City, State**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (include nonprescription)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking any medications (prescription or over the counter) for acid indigestion? NO _____ YES _____
If yes what type: _____ How long? _____

Have you ever taken Fen-Phen/Redux? NO _____ YES _____

Patient Social History

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____
Excessive Exposure At home or at work to:
Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History

	Age	**Disease(s)**	**If Deceased, Cause of Death**
Father	_____	_____	_____
		_____	
Mother	_____	_____	_____
		_____	
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
		_____	
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain between shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands/feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Payment is due at the time of service unless other payment arrangements have been made and agreed upon by both this practice and the patient in writing.

Patient Signature (Parent/Guardian if minor):_____ Date:_____

THIS BOX FOR OFFICE USE ONLY

Provider Signature _____ Date Reviewed _____

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Terms of Acceptance

We diagnose and treat musculoskeletal related conditions, including vertebral subluxations. However, if during the course of our examination, we encounter non-musculoskeletal conditions or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment of those findings, we will make our best recommendation or refer you to another health care provider. For the purpose of record keeping and training, medical information and conversations may be recorded.

Terms that may be used regarding your condition and treatment in this office include:

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which cause alteration of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's innate ability to function and heal properly.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine by instrumentation or hand.

Possible Risks: As with other health care procedures, risks and complications are a possibility after a chiropractic adjustment. A minority of patients may feel stiffness or soreness after the first few adjustments. Cerebrovascular injury or stroke could be caused if severe injuries to arteries of the neck happen.

Risk Probability: The risks associated with chiropractic care are described as "rare", similar to the risks of taking a single aspirin tablet. The probability of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be further reduced with screening procedures.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

This office uses email, text and phone to communicate with our patients.

Compliance and Disclosure

In compliance with the Texas Occupations Code and federal regulation, this is to serve as notice that Back Pain & Sciatica Center of Texas / Houston Stem Cell Solutions has financial interest in multiple healthcare facilities/entities that patients may be referred to for treatment and/or diagnostic testing. The doctors hereby notify you that you have the option of choosing alternative facilities to have your treatment and/or diagnostic testing performed. Facilities that Back Pain & Sciatica Center of Texas has a financial interest in include: Conroe Premier Imaging Center, Vision Park Premier Imaging Center, UGHS Surgicare – The Woodlands, Surgicare of The Woodlands, Preva Surgical Management-Northside, LLC. Alternative Imaging Centers within a 10 mile radius of Back Pain & Sciatica Center of Texas include Aspire Imaging Center, Aurum Diagnostic Imaging, Conroe Open MRI and Conroe Regional Medical Center.

Assignment of Health Plan Benefits and Rights as well as an Appointment and/or Designation as my Personal Representative and an ERISA/PPACA Representative and Beneficiary

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Back Pain & Sciatica Center of Texas / Houston Stem Cell Solutions** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health

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status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____

(Please Print Patient Name)

_____

(Patient Signature)

_____

(Date)

_____

(Signature of Guardian if Applicable)

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Acknowledgment of Notice of Privacy Practices

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us or unless the law authorizes or compels us to do so. You may see your records or get information about it by contacting Back Pain & Sciatica Center of Texas.

Our ***Notice of Privacy Practices*** describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like the complete Notice of Privacy Practices a copy can be given to you at your request.

You may refuse to sign this acknowledgment

By my signature below I acknowledge that I have been informed of the Notice of Privacy Practices

Patient signature Date

Printed name if signed on behalf of Patient Relationship

Additional Disclosure Authority

In addition to the allowable disclosures describe in the "Notice of Privacy Practices," I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

Any member of my immediate family: Yes___ No___

Spouse Only: Yes___ No___

Other (Please Specify): Yes___ No___

Signature: _____

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous.
Date of last menstrual period: _____

Signature: _____ **Date:** _____

Consent to evaluate and treat a minor child:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature: _____ **Date:** _____

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

__ Communication barriers prohibited obtaining acknowledgment
__ An emergency situation prevented us from obtaining acknowledgment
__ Individual refused to signature
__ Other (Please Specify) _____

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Patient Quality of Life Survey

Name: _____ Date: _____

Please take several minutes to answer these questions so we can help you get better!

1. What are you afraid your problem might be (or beginning) to affect (or will affect)? (circle all that apply)
   a) Job
   b) Kids
   c) Future ability
   d) Marriage
   e) Self- Esteem
   f) Sleep
   g) Time
   h) Finances
   i) Freedom

2. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

   _____
   _____
   _____
   _____

3. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

   _____
   _____
   _____

4. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

   _____
   _____
   _____

5. What would be different/ better without this problem? Please be specific
   a) _____
   b) _____
   c) _____