VILLAGE CHIROPRACTIC

Name:_____Date:_____ Nickname:_____

Sex:_____Birth Date: _____Age: _____Social Security #: _____

Address: _____ _____ _____ _____
Residence and Mailing City State Zip Code

Home Phone: _____Mobile Phone:_____Email: _____

Occupation: _____Employer: _____Work Phone: _____

Marital Status: S M D W Spouse's Name: _____Spouse's Birth Date: _____

No. of Children: _____Emergency Contact: _____Contact Phone: _____

How did you hear about us? ____Billboard ____Referral (Please Name) _____

____Google ____Social Media (Please List) _____

____Yelp ____Other (Please List) _____

## Primary (First) Complaint and Location

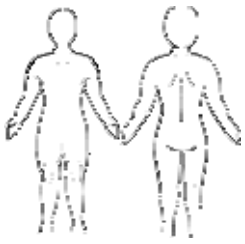
Chief Complaint (Reason for Visit): _____

When did your symptoms appear (Onset Date)?_____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____Yes _ No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

| | | | | |
|---|---|---|---|---|
| _____Sharp | _____Shooting | _____Stiffness | _____Crawling | _____Pulsating |
| _____Dull | _____Burning | _____Deadness | _____Pins and Needles | _____Prickly |
| _____Throbbing | _____Tingling | _____Stabbing | _____Stinging | _____Pounding |
| _____Aching | _____Cramping | _____Numb | _____Excruciating | |

What makes it worse?

| | | | | |
|---|---|---|---|---|
| _____Sitting | _____Lifting | _____Driving | _____Looking Down | _____Sneezing |
| _____Standing | _____Coughing | _____Walking | _____Rotating Head | _____Carrying |
| _____Bending | _____Straining | _____Exercising | _____Stress | _____Climbing Stairs |
| _____Lying Down | _____Getting out of bed | _____Looking Up | _____Bright Lights | _____Repetitive Movement |

What makes it better?

| | | | | |
|---|---|---|---|---|
| _____Ice | _____Rest | _____Pain Medications | _____Lying Down | _____Exercising |
| _____Heat | _____Tylenol | _____Mineral Ice | _____Sleeping | _____Anti-inflammatory |
| _____Massage | _____Advil | _____Muscle Relaxers | Other: _____ | |

What time of day is it worse? _____Morning _____End of day ____ _ Night _____Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____Work ____ _ Sleep _____Daily Routine ____ _ Recreation _____None

Have you seen other doctors for this condition? _____Yes _____No If yes, who? (Name)_____

Type of Treatment:_____Are you satisfied with the results of the treatment? _____Yes _____No

Do you exercise? _____None _____Infrequent _____Regular _____Frequent and Heavy

Sufficient rest _____Never _____Rarely _____Occasionally _____Moderately

Hours of sleep _____3-4 _____5-6 _____7-8 _____9-10 _____More than 10

Personal stress _____Low _____Medium _____High _____Very high

Occupational stress _____Low _____Medium _____High _____Very high

Well balanced diet _____Never _____Rarely _____Occasionally _____Regularly

Do you smoke? _____No _____Occasionally _____1 to 5 _____6 to 10 _____11-15 _____Packs per day?

Do you drink alcohol? _____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 per day

Do you drink caffeine? _____No _____Occasionally _____1 to 2 _____2 to 3 _____4 to 5 _____More than 5 per day

# Secondary Complaint and Location

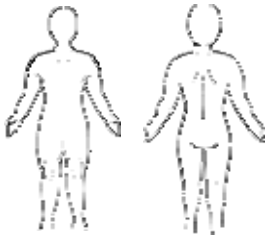
Secondary Complaint:_____

When did your symptoms appear (Onset Date)?_____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? _____Yes _ No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

_____Sharp _____Shooting _____Stiffness _____Crawling _____Pulsating

_____Dull _____Burning _____Deadness _____Pins and Needles _____Prickly

_____Throbbing _____Tingling _____Stabbing _____Stinging _____Pounding

_____Aching _____Cramping _____Numb _____Excruciating

What makes it worse?

_____Sitting _____Lifting _____Driving _____Looking Down _____Sneezing

_____Standing _____Coughing _____Walking _____Rotating Head _____Carrying

_____Bending _____Straining _____Exercising _____Stress _____Climbing Stairs

_____Lying Down _____Getting out of bed _____Looking Up _____Bright Lights _____Repetitive Movement

What makes it better?

_____Ice _____Rest _____Pain Medications _____Lying Down _____Exercising

_____Heat _____Tylenol _____Mineral Ice _____Sleeping _____Anti-inflammatory

_____Massage _____Advil _____Muscle Relaxers Other: _____

What time of day is it worse? _____Morning _____End of day _____ Night _____Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

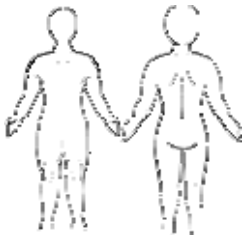
Does it interfere with your: _____Work _____ Sleep _____Daily Routine _____ Recreation _____None

# Third Complaint and Location

Third Complaint:_____

When did your symptoms appear (Onset Date)?_____

Please describe the cause of the injury: _____



Is this condition getting progressively worse? _____Yes _ No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

| | | | | |
|---|---|---|---|---|
| _____Sharp | _____Shooting | _____Stiffness | _____Crawling | _____Pulsating |
| _____Dull | _____Burning | _____Deadness | _____Pins and Needles | _____Prickly |
| _____Throbbing | _____Tingling | _____Stabbing | _____Stinging | _____Pounding |
| _____Aching | _____Cramping | _____Numb | _____Excruciating | |

What makes it worse?

| | | | | |
|---|---|---|---|---|
| _____Sitting | _____Lifting | _____Driving | _____Looking Down | _____Sneezing |
| _____Standing | _____Coughing | _____Walking | _____Rotating Head | _____Carrying |
| _____Bending | _____Straining | _____Exercising | _____Stress | _____Climbing Stairs |
| _____Lying Down | _____Getting out of bed | _____Looking Up | _____Bright Lights | _____Repetitive Movement |

What makes it better?

| | | | | |
|---|---|---|---|---|
| _____Ice | _____Rest | _____Pain Medications | _____Lying Down | _____Exercising |
| _____Heat | _____Tylenol | _____Mineral Ice | _____Sleeping | _____Anti-inflammatory |
| _____Massage | _____Advil | _____Muscle Relaxers | Other: _____ | |

What time of day is it worse? _____Morning _____End of day _____ Night _____Various Times

What percentage of the day is the condition present? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Does it interfere with your: _____Work _____ Sleep _____Daily Routine _____ Recreation _____None

# Past Health History

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

## Neurological Health History

| | | | |
|---|---|---|---|
| _____Facial Weakness | _____Loss of Balance | _____Sensation Loss | _____Memory Loss |
| _____Smell Disturbance | _____Stroke | _____Incontinence | _____Dizziness |
| _____Speech Disturbance | _____Seizures _____ | _____Ringing in Ears | _____Nervousness |
| _____Visual Disturbance | _____Numbness in Toes | _____Headaches | _____Stomach Upset |
| _____Loss of Taste | _____Numbness in Fingers | _____Irritability | _____Tension |

## Musculoskeletal Health History

| | | | |
|---|---|---|---|
| _____Abnormal Posture | _____Disc Herniation | _____Osteopenia | _____Elbow Problem |
| _____Osteoarthritis | _____Degenerative Disc Disease | _____Osteoporosis | _____Wrist Problem |
| _____Dislocation/Fracture | _____Shoulder Problem_____ | _____TMJ Syndrome | _____Ankle Problem |
| _____Lower Back Pain | _____Knee Problem_____ | _____Headaches | _____Pes Planus |
| _____Neck Pain | _____Sprain/Strain_____ | _____Tendonitis _____ | Other _____ |

## Childhood Illnesses

_____ADD / ADHD
_____Allergies / Hay Fever
_____Asthma
_____Eczema
_____Cerebral Palsy
_____Chicken Pox
_____Depression
_____Diabetes (Type I)
_____Fetal Drug Exposure
_____Food Allergies
_____Headaches
_____Hepatitis
_____Measles
_____Mumps
_____Rash
_____Scoliosis
_____Sickle Cell Anemia
_____Ear infections
_____Other_____
_____Bed Wetting

## Adult Illnesses

_____Alzheimers
_____Anemia
_____CRPS (RSD)
_____Cancer _____
_____Chicken Pox
_____Crohn's / Colitis
_____Heart Disease
_____Kidney Problems
_____Depression
_____Diabetes (Type II)
_____Liver Disease
_____Emphysema
_____Eye Problems
_____Fibromyalgia
_____Parkinson's Disease
_____STD's (unspecified)
_____Hypertension
_____Pneumonia
_____Seizure Disorder
_____Hepatitis
_____Lupus Erythema
_____Multiple Sclerosis
_____Vertigo
_____Other _____
_____Psychiatric Problems
_____Scoliosis
_____Asthma
_____Suicide Attempt(s)
_____Thyroid Problems
_____Ear Infections (frequent)

## Past Surgeries

_____Angioplasty
_____Appendectomy
_____Caesarian Section
_____Carpal Tunnel Repair
_____Coronary Artery Bypass
_____Cosmetic
_____D & C
_____Rotator Cuff
_____Hemorrhoidectomy
_____Hernia Repair
_____Hysterectomy
_____Gallbladder
_____Laminectomy_____
_____Mastectomy
_____Pacemaker Insertion
_____Knee Replacement
_____Spinal Fusion_____
_____Tympanostomy
_____Cardiac Catherization
_____Hip Replacement

## Current Medications

_____ _____ _____
_____ _____ _____
_____ _____ _____

## Vitamins and Supplements

_____ _____ _____
_____ _____ _____
_____ _____ _____

## Known Drug Allergies

_____ _____ _____
_____ _____ _____
_____ _____ _____

***The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:***

_____ _____

*Signature (Patient or Guardian)* *Date*

VILLAGE CHIROPRACTIC

**ASSIGNMENT AND INSTRUCTION FOR PAYMENT TO DOCTOR/FACILITY**

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Print Patient Name_____Employer_____

Claim Group #_____SS or ID#_____

I hereby instruct and direct the _____Insurance Company to pay by check made
Name of Insurance Company
out to and mailed directly to:

**Village Chiropractic**
**7901 Research Forest Dr. #900**
**The Woodlands, Texas 77382**

**OR**

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

**c/o**

**7901 Research Forest Dr. #900**
**The Woodlands, TX 77382**

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy has payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorized to release of any information pertinent to any insurance company, adjustor, or attorney involved in this claim.

Dated at Montgomery County, this _____ day of _____,2023

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder