# Welcome to Frisco Spinal Rehabilitation

## Personal History

Name:_____ Address:_____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ DOB: _____ Age: _____ Sex: ☐M ☐F
Cell Phone: _____ E-mail Address: _____
Social Security #:_____ Driver's License Number: _____
Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Business Employer: _____ Type of Work: _____
Business Phone: _____
Name of Spouse: _____ Spouse's Social Security #: _____
Spouse's Employer: _____ Business Phone: _____
Type of Work: _____ Name & Ages of Children _____
Referred To This Office By: _____

Name & Number of Emergency Contact: _____Relationship:_____

Who Is Responsible For Your Bill? ☐ You ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare

☐ Personal Health Insurance (Name) _____

Insured Person's Name _____ ☐ DOB: _____

## Current Health Conditions

Primary Purpose of Visit: _____

Other Doctor Seen For This Condition ☐ Yes ☐ No Who? _____
Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No
Date of Accident: _____

Have You Made A Report Of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____
_____

## Past Health History

Please Check & Describe:

Major Surgery/Operation: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____
Major Accidents Or Falls: _____
_____
Hospitalization (Other Than Above): _____
_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit: _____

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

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

□ Pneumonia
□ Rheumatic Fever
□ Polio
□ Tuberculosis
□ Whooping Cough
□ Anemia
□ Measles
□ Mumps
□ Small Pox
□ Chicken Pox
□ Diabetes
□ Cancer
□ Heart Disease
□ Thyroid
□ Influenza
□ Pleurisy
□ Arthritis
□ Epilepsy
□ Mental Disorders
□ Lumbago
□ Eczema

**INTAKE**

□ Coffee
□ Tea
□ Alcohol
□ Cigarettes
□ White Sugar

Have you been tested HIV positive? □ Yes □ No

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS?**

**MUSCULO-SKELETAL CODE**

□ Low Back Pain
□ Pain Between Shoulders
□ Neck Pain
□ Arm Pain
□ Joint Pain/Stiffness
□ Walking Problems
□ Difficult Chewing/Click Jaw
□ General Stiffness

□Gas/Bloating After Meals
□ Heartburn
□ Black/Bloody Stool
□ Colitis

**GENITO-URINARY CODE**

□ Bladder Trouble
□ Discolored Urine

**FEMALES ONLY:**

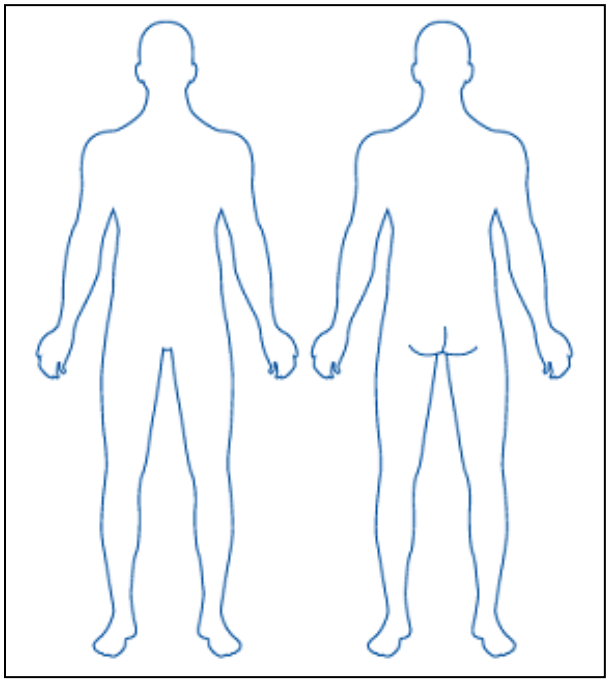
When was your last period? _____
Are you pregnant?
□ Yes □ No

**NERVOUS SYSTEM CODE**

□ Nervous
□ Numbness
□ Paralysis
□ Dizziness
□ Forgetfulness
□ Confusion/Depression
□ Fainting
□ Convulsions
□ Cold/Tingling Extremities
□ Stress

**C-V-R CODE**

□ Chest Pain
□ Short Breath
□ Blood Pressure Problems
□ Irregular Heartbeat
□ Heart Problems
□ Lung Problems/Congestion
□ Varicose Veins
□ Ankle Swelling
□ Stroke



***Please outline on the diagram the area of your discomfort***

**GENERAL CODE**

□ Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches
□ Stuffed Nose

**EENT CODE**

□ Vision Problems
□ Dental Problems
□ Sore Throat
□ Ear Aches
□ Hearing Difficulty

**GASTRO-INTESTINAL CODE**

□ Poor/Excessive Appetite
□ Excessive Thirst
□ Frequent Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Gall Bladder Problems
□ Weight Trouble
□ Abdominal Cramps

**MALE/FEMALE CODE**

□ Menstrual Irregularity
□ Menstrual Cramps
□ Vaginal Pain/Infection
□ Breast Pain/ Lumps
□ Prostate/Sexual Dysfunction
□ Other Problems
□ _____
□ _____
□ _____

**FAMILY HISTORY**

The following members have a same or similar problem as I do:

□ Mother
□ Father
□ Brother
□ Sister
□ Spouse
□ Child

**INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE AT FRISCO SPINAL REHABILITATION**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. David Kaff, D.C. and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

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 muscle soreness, rib injuries with manual thoracic/lumbar spine adjustments, remote possibility of strokes with manual upper cervical adjustments, physical therapy burns with ice or heat modalities, and soft tissue injuries with stretching or manual adjustments. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels, at the time, based upon the facts then known, is in my best interests.

**FEMALES ONLY**:
Regarding diagnostic x-rays (if necessary), I acknowledge that I am not pregnant, nor am I trying to get pregnant. X-ray radiation is dangerous to a developing fetus. If I suspect that I may be pregnant, I have made the doctor aware of this so that x-rays are not performed. The date of the first day of my last menstrual cycle is _____/_____/_____

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about my consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**TO BE COMPLETED BY PATIENT**

Patient's Name_____ Patient Signature _____
Please Print
Date Signed _____ Witness Signature _____

**TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSCIALLY OR LEGALLY INCAPACITATED**

Patient's Name_____ Patient Signature _____
Please Print
Date Signed _____ Signature of Representative _____

Relationship of Authority or Representative _____

Translated by _____ Date _____

# MASTER ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

**To Whom It May Concern:**

I, _____, hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to Frisco Spinal Rehabilitation (Office) such sums as may be due and owing this Office in consideration for services rendered to me, both by reason of an accident or illness, and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits, medical payment benefits, No-Fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services, refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company, and authorize this Office to prosecute said cause of action either in my name or in the Office's name, and further I authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I further understand and agree that this Master Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Master Assignment, Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I hereby state and agree that a photocopy of this document will be as valid and binding on all parties involved as the original copy.

Date: _____ Signed: _____

# Frisco Spinal Rehabilitation Privacy Policies

I, _____, give consent to Frisco Spinal Rehabilitation, for the use and disclosure of my Protected Health Information (PHI) for the specific purpose of treatment to me, receiving payment for service rendered to me, and for general administrative operations of the practice

_____ (*Initial*)

I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree to these restrictions.

_____ (*Initial*)

You may contact me for appointment reminders, schedule changes, or other needs by the following methods (fill in only the methods by which you desire to be contacted):

Home Telephone:
Cell Phone:
Work Telephone:
Email Address:
Home Address:

Work Address:

Marketing: Occasionally we send out newsletters, announcements, and special occasion cards. If you wish to receive these, please initial here:

_____ *(Initial*)

I have received a copy of the Privacy Policies Notice. I have read the Notice and understand that I do not have to sign this authorization and that my refusal will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying Frisco Spinal Rehabilitation, in writing.

Signature _____ Date _____

Print Name _____