Weir Family Chiropractic

& Spinal Decompression Center

Welcome to our office!

Please fill out our Health Record as completely and accurately as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you.
Our commitment to you is to promote the highest quality of health and well-being with Chiropractic Care.

About the Patient

Name_____
Preferred Name_____
Address_____
City_____ State_____Zip____
Home Phone (_____)_____

Cell Phone (_____) _____
If you would like appointment reminders sent by text please provide your cell phone carrier_____

Work Phone (_____) _____
Birthdate_____ Age_____
Gender: M F Marital Status: M S
Occupation_____
Primary Physician_____
Email: _____

About the Spouse or Parent

Spouse's Name_____
Children_____

If the patient is under 18 years of age:
Mother's Name_____
Father's Name_____

Medications I Now Take

___ Nerve Pills ___ Stimulants
___ Pain Killers ___ Blood Thinner
___ Muscle Relaxer ___ Tranquilizer
___ Blood Pressure Medication
___ Insulin ___ Cholesterol Medication
___ Anti-depressant or Anti-anxiety
___ ADHD Other:_____

Experience with Chiropractic

Who may we thank for referring you to this office? _____
Have you been adjusted by a Chiropractor before? Y N
Reason for those visits? _____
Approximate date of last visit? _____
How did you respond to your care? _____

Stress & Behavioral Habits

Rate your current level of stress on a scale of 0 (none) to 10 (highest) _____
How many hours do you sleep at night? _____
Do you have difficulty: ___ falling asleep ___ staying asleep ___ waking refreshed
Do you feel a mid-day slump? Y N What do you do for it? _____
What type of exercise do you engage in? _____
How often? _____
What is your diet like? (Be honest!) _____
_____% plant based foods _____% animal protein ___% dairy ____% prepared foods
How many meals per week do you eat out? _____

Do you smoke? Y N
Do you drink alcohol? Y N
Do you drink soda? Y N
Do you drink coffee? Y N
Do you take vitamins? Y N
What kind? _____

Health Conditions

Please check any of the conditions that you experience. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Related to the **Cervical Spine** (neck):

___ Dizziness ___ Sinus / Allergies ___ Headaches/ Migraines ___ Neck Pain
___ Depression ___ Sleeping Difficulty ___ Ringing in the Ears ___ Fatigue
___ Irritability ___ Weight Difficulty ___ Visual Disturbances ___ Dry Mouth
___ Thyroid Problems ___ Difficulty Concentrating ___ Frequent Sighing or Hiccups

_____
_____
_____

Related to the **Thoracic Spine** (mid-back):

___ Heart Problems ___ Shortness of Breath ___ Asthma
___ Reflux or Indigestion ___ Gall Bladder Problems ___ Mid-Back Pain
___ Chest Pain ___ Poor Posture ___High Blood Pressure

_____
_____
_____

Related to the **Lumbar Spine** (low back):

___ Low Back Pain ___ Freq. Urinary Tract Infections ___ Digestive Disturbances
___ Irritable Bowel ___ Problems with Urination ___ Colitis
___Constipation ___ Pain that goes down my leg(s) Right / Left / Both

_____
_____
_____

For Men: ___ Erectile Dysfunction ___ Prostate Problems
For Women: ___ Irregular Cycles ___ PMS ___ Difficulty Getting Pregnant
Are you currently pregnant? Y N If yes, how far along? _____ Due date_____
Are you currently nursing? Y N Are you taking birth control? Y N

Have you or anyone in your family been diagnosed with the following?
___ Heart Disease ___ Stroke ___ Diabetes ___ Cancer
Injuries and date of occurrence: _____
_____
_____

Surgeries or Hospitalizations & dates of occurrence: _____
_____
Other conditions not listed: _____
_____

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1108 S. Elm St.
Carrollton, TX 75006
972.242.6886

www.carrolltonchiro.net

Initial Consultation Form

Patient's Name: _____ Date: _____

Reason for this visit (main complaint):_____
When did this begin? _____
Has this condition: ___ Gotten worse ___ Stayed the Same ___ Comes & Goes
How did this begin? _____
Is this problem related to a job or auto accident? Y N
Has this condition occurred before? Y N
If yes, explain: _____
Have you sought other treatment for this before? Y N
If yes, type of treatment: _____ Results: _____

Overall Frequency of Complaint (Please circle one)
Constant - 100% **Frequent** - 75% **Intermittent** - 50% **Occasional** - 25%

Overall Intensity of Complaint
____ **Minimal** (An annoyance but has no effect on activity)
____ **Slight** (Tolerable with some impairment to activity)
____ **Moderate** (Tolerable with marked impairment of activity)
____ **Severe** (Intolerable and cannot perform activities)

What does your problem feel like? Stabbing Throbbing Shooting Achy Crampy Tingly
Other: _____

Is this problem affecting / radiating to any other area of your body? If yes, please explain:
_____

What other aspects of life does this problem affect? (Family, work, recreation, sports, sleep)
_____

What aggravates your problem? _____
What relieves your problem? _____
What is this problem preventing you from enjoying in your life? _____
_____

Doctor's notes: _____
_____
_____
_____

Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. We, at Weir Family Chiropractic, wish to have the most impact on the quality of lives of our patients. Although chiropractic care is often thought of as a system of care to relieve symptoms, to us it is about relieving the constraints of limitations of malfunction thereby allowing you to thrive, heal, love, produce, and enjoy a vibrant life.

This worksheet is designed to allow us to understand what those benchmarks are **for you**. There are no wrong answers, but remember: "fuzzy targets don't get hit"! The more precise you are the better. In understanding what your true goals are, we will better be able to assist you in achieving them.

It is implied that you would like to resolve your symptoms (if you have any). What we would like to know is WHY.
For example:
A patient with low back pain may have a goal of

- Playing 9 holes of golf
- Being able to hold his / her child
- Wear high heels (or "cute" shoes) again
- Be able to produce more at work
- Improve relationships with family due to improvement of irritability / depression

Or, in the case of a child with allergies or asthma, goals may include something like:

- Be able to play Soccer outside with friends
- Reduce days missed at school

Etc.

MY ULTIMATE GOALS in seeking chiropractic are:

_____

_____

_____

After completing your paperwork, if there were ONE THING in your review of systems (Health Complaints) that improvement of would most impact my life, I would choose:
____ The complaint that brought me here ____ other: _____

What type of care are you looking for?

- ___ **Relief Care**: Symptomatic relief of pain or problem.
- ___ **Restorative Care**: Correcting the cause of the problem as well as symptoms.
- ___ **Comprehensive Care**: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- ___ **I'm not sure.**

Weir Family Chiropractic Fee Schedule and Financial Policy

Service	Fee
Consultation	No Charge
Initial Exam / Computer Scans	$70 - $130
X-Rays (Per View)	$40 - $130
Re-examination / Computer Scans	$70
Adjustments	$60
Therapy Modalities	$20 - $50
Spinal Decompression w/ Adjustment	$100
Wellness Adjustment Plans	$200 - $500/month

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. Our main concern is your health and well-being and we will do our best to help you.

Insurance: We will verify all insurances and your benefits per your agreement with your carrier. After verification the Doctor will give her recommendations and an appropriate plan will be designed for each individual.

Missed Appointments

Here at Weir Family Chiropractic we strive to provide you with the utmost professionalism and excellence of service. Our commitment to your well-being and health is something we take seriously.

We care about you and realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we recommend to you.

- Your faithfulness to the recommended number of adjustments is key to ensuring optimum results.
- With the exception of emergencies, it is vital that you keep all your appointments. If you need to reschedule, we prefer that you do so within the same week.
- In the instance of a no show without notice by phone we reserve the right to charge you a $20 fee.

Thank you for understanding. We greatly appreciate you as our patient and strongly desire excellent results and success for you!

I understand and agree to all the information written above.

Patient Signature: _____ Date:_____

Authorization For Care

Chiropractic has one primary objective: to optimize the health of the nervous system by proper alignment of the spine. We do not offer to diagnose or treat any condition other than spinal subluxation. However, if we encounter a non-chiropractic or unusual finding, we will advise you of the findings and refer you to the appropriate provider.

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I understand that all original files belong to the office.

Patient Signature: _____ Date: _____

Release and Consent

Insurance: I clearly understand and agree I am responsible for all bills incurred at this office. I understand that payment is due at time of service unless a financial agreement is made in advance. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I understand and agree that my health and / or auto insurance is an arrangement between an insurance carrier and myself. I understand that the Doctor's office will submit my insurance on my behalf, and I assign all rights and benefits directly to the provider of services rendered. I agree to pay, in full, any charges denied by my insurance carrier.

Patient Signature: _____ Date: _____
Parent or Spouse's Signature: _____ Date: _____

X-ray: I hereby authorize x-ray radiographs for this appointment or any future appointment for myself or for my child and understand that is my responsibility to inform the clinic beforehand if there are any contraindications to x-ray examination, including pregnancy (if applicable).

Patient Signature: _____ Date: _____

Minor: I authorize treatment of my minor child.

Patient Signature: _____ Date: _____

HIPAA Consents

NOTICE OF PRIVACY PRACTICE RECEIPT:

I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: _____ Date: _____

Signature: _____
Patient's Date of Birth: _____

For Personal Representative of the Patient (only if applicable)

Print Name of Personal Representative: _____
Relationship (parent, guardian, etc.): _____
Signature of Personal Representative: _____
Reason Patient unable to sign: _____

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Weir Family Chiropractic is committed to protecting your personal health information. Personal health information may include such items as: medical notes from your doctor, a claim from your provider listing your diagnosis, a medical treatment that you received, or laboratory/diagnostic test results. This notice about protecting your health information is required by law. It tells you about your rights and how we use and disclose your health information. **Please read Carefully**

YOUR HEALTH INFORMATION RIGHTS

- Request a restriction on certain uses and disclosures of your health information; however, we are not required to approve your request.
- Request that we notify you about your health information in a way or at a location that will help you keep your information confidential.
- Receive a list of disclosures we have made of your health information.
- In writing at any time, withdraw your permission for us to disclose your health information, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own health information.
- Ask us to change your health information if you believe it is incorrect or incomplete. We may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.
- If you need to disclose private information you may request a consult with Dr. Weir.

HOW WEIR FAMILY CHIROPRACTIC MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.
PAYMENT: We may use and disclose your health information to obtain payment for services we provided to you.
HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with chiropractic operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
REQUIREMENTS BY LAW: We may use and disclose your health information when required to do so by law.

- To reply to proper requests for your health information from a court or other legal agency.
- To report information for public health, such as reporting victims of abuse, neglect or domestic violence or reporting to the Food and Drug Administration problems with products or reactions to medications.
- To report information for public safety, such as to prevent the spread of a serious threat to the health and safety of a particular person or the general public.
- To allow funeral directors, medical examiners, or coroners to carry out their lawful duties, such as to complete a death certificate for the state.
- To comply with laws and regulations related to Worker's Compensation.
- To allow other government agencies to provide you with benefits and services.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your health information to government health agencies for health oversight reasons, such as program audits or licensure reviews.
RESEARCH: We may use your health information for approved research purposes, such as for study to cure a dise ase.
SPECIAL GOVERNMENT FUNCTIONS: We may such as protection of public officials or reporting to various branches of the armed services, may require the use or disclosure of your health information.

OBLIGATIONS OF WEIR FAMILY CHIROPRACTIC

- Maintain the privacy of your protected health information.
- Provide you with the Notice of its legal duties and privacy practices with respect to your health information.
- Obtain your written authorization to use or disclose your health information for reasons other than those listed in this Notice and permitted by law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if we are unable to agree to requested restriction on how your information is used or disclosed.
- Allow reasonable requests you may make to notify you about your health information in a way or at a location that will help you keep your health information confidential.

Weir Family Chiropractic reserves the right to change its information practices. The new provisions will be effective for all protected health information that Weir Family Chiropractic maintains. Revised notices will be made available to you by written notices and on the Weir Family Chiropractic website at: www.carrolltonchiro.net

COMPLAINTS:
If you have a complaint about how Weir Family Chiropractic handles your health information, or if you otherwise believe that your privacy rights have been violated by Weir Family Chiropractic, your complaint should be directed to: Weir Family Chiropractic, 1108 S. Elm St. Carrollton, Texas 75006 Attention: Privacy Contact

If you are not satisfied with the manner in which Weir Family Chiropractic handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, D.C. There will be no retaliation by Weir Family Chiropractic if you file a complaint.