PATIENT PERSONAL / CONFIDENTIAL DATA

Date: _____

Patient Name: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____**Cell #**: _____
Employer: _____
How did you learn about this clinic (Google, Instagram, FaceBook, TikTok, Family & Friends, Dr. referral) : _____
Email Address:_____
Are you? Married ☐ Divorced ☐ Single ☐
If married: Spouse's / Partner's name _____
Do you have kids? Yes ☐ No☐
If yes, how many and age _____

Purpose of this appointment and list your complaints:

_____

_____

_____

Date of Injury: _____ Time: _____A.M. or P.M.
Location: _____
How did the accident occur? ☐ Auto ☐ on the Job ☐ Other, _____
Please describe the circumstances and what makes the condition(s) better or worse.

_____

_____

Have you seen another Doctor for this condition? Yes or No Doctor's Name: _____
Your primary Doctor: _____ Phone #: _____

What is your commitment level to improve your health: _____%

Insurance Information

I understand and agree the health and accident insurance policies are and agreement between the insurance carrier and myself. Furthermore, I understand that this chiropractic Office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office Will be credited to my account upon receipt, However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional serviced rendered to me will immediately do and payable.

Patient's Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic service that he/she deems necessary in my case. As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These complications include fractures, disk injuries and stroke. I further authorize him/her to disclose all or any part of my (patients) records to any persons or corporation in which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____

Patient's or Guardian's Signature: _____

HEALTH QUESTIONNAIRE

MUSCULO SKELETAL VASCULAR SYSTEM

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

GENITO-URINARY SYSTEM

- ☐ Bladder
- ☐ Excessive Urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

GASTRO-INTESTIONAL SYSTEM

- ☐ Poor Appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult Swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

CARDIO-VASCULAR SYSTEM

- ☐ Chest Pain
- ☐ Pain over heart
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

Nervous System

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Eye, Ear, Nose AND Throat

- ☐ Eye stain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noise
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Drug Abuse
- ☐ _____

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ **YES** ☐ **NO**

Patient's Signature _____

Patient Accepted? ☐ **Yes** ☐ **No**

Doctor's Signature _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at the worst.

PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES HOW YOUR TYPICAL PAIN LEVEL AFFECTS THESE SIX CATEGORIES OF ACTIVITIES.

1 Family/ at home responsibilities such as yard work, chores around the house or driving the kids to school –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

2 Recreation including hobbies, sports or other leisure activities –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

3 Social activities including parties, theater, concerts, dining – out and attending other social functions –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

4 Employment including volunteer work and homemaking tasks –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

5 Self- care such as taking a shower, driving or getting dressed –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

6 Life- support activities such as eating and sleeping –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — **TOTALLY UNABLE TO FUNCTION**

PATIENT NAME _____ **DATE**_____

Patient Consent / HIPAA Understanding

I understand that, under the Health Insurance Portability & Accountability of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can/will be used to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from the third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Tricare Chiropractic has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing any time, except to the extent that you have taken action relying on this consent.

I understand that by signing below I give my consent to be examined and treated by Dr. Tien Adrian Trinh and any/all other staff of Tricare Chiropractic. All staff members at Tricare Chiropractic are dedicated to treat me with the utmost respect and professionalism. They will strive to provide me with the best chiropractic care and associated therapies they are able to provide. If I have any comments, complaints, or concerns associated with this facility, I will discuss these issues with the Office Manager on site immediately.

_____
Patient Name

_____ _____
Signature Date

_____
Relationship to Patient(IF under 18)

_____ _____
Witness Date

Tricare Chiropractic, P.A.
800 W Arbrook Blvd. Suite 110
Arlington, TX 76015