Houston Sports Rehabilitation & Nutrition Center

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ABOUT YOU

Today's Date: _____/_____/_____ File #: _____

Patient Name: _____ ❑ Male ❑ Female
LAST FIRST MI

What You Prefer To Be Called: _____

Birthdate: _____/_____/_____ Age:_____ SS#: _____

Mailing Address: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Other Phone #: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

Occupation: _____

Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Separted ❑Widowed

Spouse's Name:_____ Do you have children? ❑Yes ❑No How many?_____

REASON FOR VISIT

The reason for this visit is a result of (Please circle): work, sports, auto, trauma or chronic.

(*Explain what Happened*) :_____

_____

Please describe the pain & its location: _____

_____

When did condition begin? _____/_____/_____

Is this condition getting worse? ❑Yes ❑No ❑Constant ❑Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine. If so, please explain: _____

_____

Have you had this or similar conditions in the past? ❑Yes ❑No If so, please explain: _____

_____

Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where?_____

Have you ever been treated by a Chiropractor before? ❑Yes ❑No

If so, whom? _____ Phone #:_____

IN THE EVENT OF EMERGENCY

Who should we contact? _____

Relation:_____

Home Phone #:_____ Work Phone #:_____

Who is your Medical Doctor?_____ Phone :_____

HEALTH HISTORY

Are you taking any over-the-counter medications?

_____

Are you taking Prescription Medications? ❑ No ❑ Yes If so, please list medication and dosage: _____

_____

_____

Do you take Supplements? ❑ No ❑ Yes If so, please list name & dosage: _____

_____

_____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / AIDS	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Do you: Exercise? ❑Yes ❑No
Are you on a special diet: ❑Yes ❑No
Since: _____/_____/_____
Do you smoke? ❑No ❑Yes How Much? _____
How Long? _____
For women: Are you taking Birth Control? ❑Yes ❑No
Are you Pregnant? ❑No ❑Yes / How Long?_____
Nursing ❑Yes ❑ No

Please list any other serious medical condition(s) you have or ever had:_____

_____

Please list anything that you may be allergic to:_____

List previous surgeries/treatments with dates:_____

List any past serious accidents with dates:_____

Family Health History (please specify): _____

_____

INSURANCE INFO

Co. Name:_____
Address:_____
_____
CITY STATE ZIP
Phone #: _____
Insured's ID#:_____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Date of Birth: ___/___/___
Insured's Employer: _____
Please inform front desk of 2nd Insurance source.

ACCOUNT INFO

Person ultimately responsible for account
Name:_____
Relation:_____
Billing Address:_____
_____
SSN: _____D.L.#:_____
Work Phone#:_____
Payment method: ❑ CASH ❑ Check
_____ Exp. Date ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you wil be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse