

373 ½ West 19th, B2, Houston, TX 77008

Ph: 832-498-2236, Fax: 888-811-8540

NEW PATIENT INFORMATION:

 □ Male □ Female Today’s Date: \_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone #: □ Home □ Cell □ Work Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please contact me via: EMAIL PHONE TEXT Please circle all that apply.

MEDICAL HISTORY

Have you been treated for any conditions in the last year? □ YES □ NO

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last x-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What vitamins, minerals, herbs, or special diets do you currently take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL/FAMILY HISTORY

Have you ever: If yes, briefly explain below.

* Had broken bones? □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Been hospitalized? □ YES □ NO ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Been in an auto accident? □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Had sprains/strains? □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Had surgery? □ YES □ NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

Do any family members have any present or past health conditions that may concern your health? Please describe below. (Example: heart disease, diabetes, cancer, arthritis, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HABITS

 None Light Moderate Heavy None Light Moderate Heavy

Alcohol □ □ □ □ Water □ □ □ □

Coffee □ □ □ □ Salty Foods □ □ □ □

Tobacco □ □ □ □ Sugary Foods □ □ □ □

Drugs □ □ □ □ Artificial Sweeteners □ □ □ □

Exercise □ □ □ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_ □ □ □ □

Sleep □ □ □ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_ □ □ □ □

Appetite □ □ □ □

Soft Drinks □ □ □ □

CURRENT COMPLAINT

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your present major complaints: Pain Scale 0-10 (10 being the worst)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had this condition in the past? □ YES □NO

If yes, how was it treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had chiropractic care in the past? □ YES □NO

If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had physical therapy in the past? □ YES □NO

If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anything make the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anything make the pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain every day? □ YES □NO Is it constant? □ YES □NO

Do your symptoms interfere with daily life? □ YES □NO

Does your pain wake you up at night? □ YES □NO

When is your pain worse? (Example: morning, night, work hours) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does change in weather affect your pain? □ YES □NO

Any other information you would like to share:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever suffered from any of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Alcoholism  |  | Excessive Menstruation |  | Pacemaker |
|  | Allergies |  | Eye Pain or Difficulties |  | Polio |
|  | Arteriosclerosis |  | Fatigue |  | Poor Posture |
|  | Arthritis  |  | Frequent Urination |  | Prostate Trouble |
|  | Asthma |  | Headaches |  | Sciatica |
|  | Back Pain |  | Hemorrhoids |  | Shortness of Breath |
|  | Breast Lumps |  | High Blood Pressure |  | Sinus Infection |
|  | Bronchitis |  | Hot Flashes |  | Sleep Problems/Insomnia |
|  | Bruise Easily |  | Irregular Heart Beat |  | Spinal Curvatures |
|  | Cancer |  | Irregular Cycle |  | Stroke |
|  | Chest Pain/Conditions |  | Kidney Infection |  | Swelling of Ankles |
|  | Cold Extremities |  | Kidney Stones |  | Swollen Joints |
|  | Constipation |  | Loss of Memory |  | Thyroid Conditions |
|  | Cramps |  | Loss of Balance |  | Tuberculosis |
|  | Depression |  | Loss of Smell |  | Varicose Veins |
|  | Diabetes |  | Loss of Taste |  | Venereal Disease |
|  | Digestion Problems |  | Neck Pain/Stiffness |  | Other:  |
|  | Dizziness |  | Nervousness |  | Other:  |
|  | Ears Ringing |  | Nosebleeds |  | Other:  |

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A = Ache B = Burning N = Numbness O = Other P = Pins & Needles S = Stabbing



**I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges, but that I will be informed of any charged services before they are performed.**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CONSENT TO TREAT MINOR CHILD

I hereby authorize Nataly Perez, DC, LLC and its providers and staff to administer a physical examination and treatment as it deems necessary to the patient listed at the top of this page. I am legally authorized to sign this consent.

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT TO RELEASE INFORMATION

I understand and have been provided with a Notice of Privacy Practices that provides a complete description of my health information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Nataly Perez, DC, LLC reserves the right to change their notice and practices.

I understand that I may revoke this consent in writing, except to the extent that Nataly Perez, DC, LLC has already taken action in reliance thereon.

I consent to the use and disclosure of my health information for treatment, payment, and healthcare procedures as described in the Notice of Privacy Practices.

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities (“payers”), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, or injuries, or illnesses, past, present, or future, to pay directly and exclusively in the name of Nataly Perez, DC, LLC such sums as may be owed said offices for charges incurred by me at the office relating to my condition (“charges”), with such payment to be made exclusively in the name of Nataly Perez, DC, LLC.

For the purposes of this document herein (“assignment”), “proceeds” shall include, but not be limited to, monies/proceeds from any settlement, judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no fault coverage, uninsured and underinsured motorist coverage, third‐party liability distributions, disability benefits, worker’s compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to office any information regarding my coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize Nataly Perez, DC, LLC to endorse/sign my name on any and all checks listing me as payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_