WHITE INTEGRATED HEALTH CLINICS, PLLC

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PHONE: (817) 625-1165
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WATERSIDE LOCATION:
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PHONE: (817) 349-7541
FAX: (817) 349-7549

Please complete this questionnaire. Your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily to the treatment, we will not accept your case. – Thank You

Confidential Patient Information

Date: _____

Patient Name: _____ Age: _____
Last First M.I.

Address: _____ Sex: ☐ Male ☐ Female

_____ D.O.B. _____
City State Zip Code

Email Address: _____ Number of Children: _____

Social Security #: _____ Driver's License #: _____

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Employer/Occupation: _____ Employer Phone #: _____

Does work involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name: _____ Spouse's D.O.B. _____

Spouse's Occupation/Employer: _____

Name of Primary Care Physician: _____ Phone #: _____

How did you hear about our clinic? _____

Contact Information

Preferred Contact Method? _____ Time of Day: _____

Cell #: _____ Work #: _____ Ext._____

Other Phone Numbers: _____ May We Leave a Voicemail? ☐ Yes ☐ No

In Case of Emergency

Name: _____ Relationship: _____

Cell #: _____ Work #: _____ Ext._____

Health History

Have you ever had Chiropractic care before? ☐ Yes ☐ No

What treatment have you already had for your condition?

☐ Medication ☐ Chiropractic Care ☐ Surgery ☐ Physical Therapy ☐ None ☐ Other _____

Name of other doctors who have treated you for this condition: _____

Please list any surgical operations you have had: _____

_____

Please list any unusual diseases/illnesses you may suffer from: _____

_____

Please list any medications you are currently taking: _____

_____

_____

Please list any allergies you have, including drug reactions: _____

_____

Smoking Status: ☐ Never ☐ Former ☐ Current (Everyday) ☐ Current (Occasional)

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Patient Condition

Reason for visit: _____

When did your symptoms appear? _____

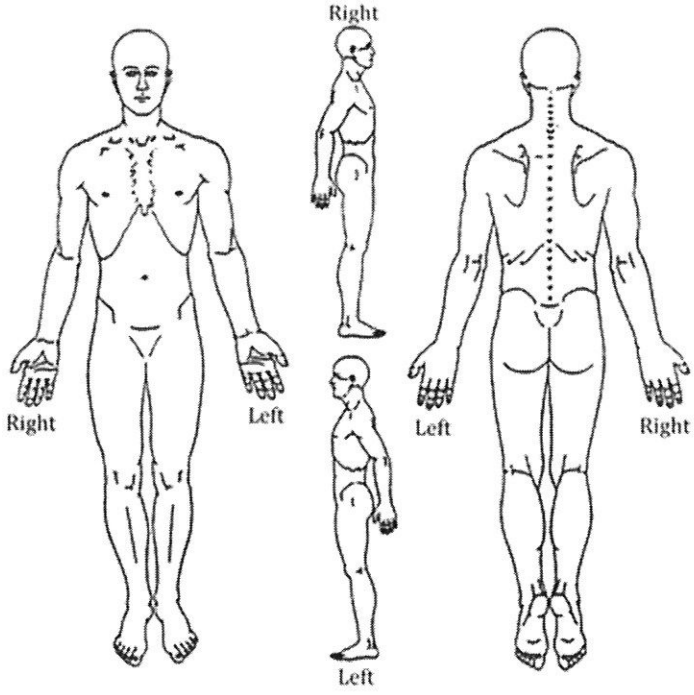
Is your condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Rate the severity of your pain: |·····|

0 no pain 5 10 worst pain

Mark an X on the picture in the places where you have pain, discomfort, numbness, or tingling.



Description of Symptom(s)

Please check all that apply:

☐ Headaches	☐ Front of Head	☐ Top of Head	☐ Back of Head
	☐ Left Side	☐ Right Side	☐ Both
☐ Jaw	☐ Left Side	☐ Right Side	☐ Both
☐ Neck	☐ Left Side	☐ Right Side	☐ Both
☐ Shoulder	☐ Left Side	☐ Right Side	☐ Both
☐ Upper Arm	☐ Left Side	☐ Right Side	☐ Both
☐ Elbow	☐ Left Side	☐ Right Side	☐ Both
☐ Forearm	☐ Left Side	☐ Right Side	☐ Both
☐ Wrist	☐ Left Side	☐ Right Side	☐ Both
☐ Hand	☐ Left Side	☐ Right Side	☐ Both
☐ Upper Back	☐ Left Side	☐ Right Side	☐ Both
☐ Mid Back	☐ Left Side	☐ Right Side	☐ Both
☐ Low Back	☐ Left Side	☐ Right Side	☐ Both
☐ Chest	☐ Left Side	☐ Right Side	☐ Both
☐ Ribs	☐ Left Side	☐ Right Side	☐ Both
☐ Hip	☐ Left Side	☐ Right Side	☐ Both
☐ Buttocks	☐ Left Side	☐ Right Side	☐ Both
☐ Thigh	☐ Left Side	☐ Right Side	☐ Both
☐ Knee	☐ Left Side	☐ Right Side	☐ Both
☐ Ankle	☐ Left Side	☐ Right Side	☐ Both
☐ Foot	☐ Left Side	☐ Right Side	☐ Both

☐ Other: _____

Please describe the pain:

☐ Aching	☐ Dull	☐ Spasm
☐ Burning	☐ Numbness	☐ Stinging
☐ Constricting	☐ Pounding	☐ Throbbing
☐ Cramping	☐ Sharp	☐ Tingling
☐ Cutting	☐ Shooting	☐ Other: _____

On average, how much of the day are you in pain?

☐ 25 % of the day	☐ 75% of the day
☐ 50% of the day	☐ 100% of the day

Does the pain radiate? ☐ No ☐ Yes If yes, where? _____

_____

Does the pain affect your daily activities? ☐ No ☐ Yes

If yes, which activities are affected the most? _____

_____

What increases the pain? _____

What decreases the pain? _____

Insurance Information

Insurance Company Name: _____

Policy/ID #_____ Group # _____

Is the patient covered by a second insurance company? ☐ Yes ☐ No

2nd Insurance Company Name: _____

Do you have Personal Injury Protection (PIP) coverage? ☐ Yes ☐ No

Auto Insurance Company Name: _____ Phone # _____

Primary Insured Information

Are you the primary insured for your insurance? ☐ Yes ☐ No

If yes, please skip to the next section. If no, please continue.

Primary Insured Name: _____ D.O.B. _____

Primary Insured SS#: _____ Employer: _____

Relationship to Patient: _____

Women Only

Date of last menstrual period: _____

Is there a possibility that you are pregnant? ☐ Yes ☐ No

*** I understand that the examination I am having involves radiation, and that radiation may cause injury to the unborn fetus, although the likelihood of such injury is slight. My physician feels that the information to be gained from the examination is important to my health, and I therefore wish to have x-rays performed.

If you think you might be pregnant, please inform the
Technologist prior to the examination.

Patient Signature: _____ Date: _____

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

It is our office policy to make certain that we provide all persons with a free consultation to determine if theirs is a chiropractic problem.

Cost Estimates

Complete Orthopedic/Neurological/Physical Exam	$150.00
Spinal X-Ray and Exam (Two views)	$198.00
Spinal X-Ray and Exam (Scoliosis study)	$75.00
Rapid Axial Decompression (Ring Dinger®)	$150.00
Computerized Spinal Disc Decompression	$80.00
Cryofos Neuro Reflex Stimulation	$80.00
MLS Cold Laser Therapy	$60.00
Interim/Update Examinations	$85.00
Chiropractic Adjustment	$70.00
Acupuncture	$70.00
Electrical Therapy	$30.00
Ultrasound / Galvanic Therapy	$35.00
Intersegmental Traction	$25.00
Diathermy	$25.00

** All cases vary. The doctor will handle patients from a case-to-case basis; therefore, charges may vary. **

If you understand and agree with all the above office policies, please sign below.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____

Doctor's Signature: _____

Accident Information

Is this condition due to an accident? ☐ **Yes** ☐ **No (**If NO, please skip)
Type of Accident: ☐ Automobile ☐ Work ☐ Other: _____

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer
☐ Workers' Comp Commission ☐ Other: _____

Was a police report made? ☐ Yes ☐ No

Please explain **in detail** how your accident/injury occurred:

_____
_____
_____
_____
_____
_____
_____

Exact accident/injury Date: _____ (mm/dd/yyyy)
Accident/Injury Time: _____ (A.M. / P.M.)
Accident/Injury Location: _____

Where did you feel pain immediately after the accident?_____
_____

List the extent of your injuries as you know them:_____
_____

Before the injury were you capable of working on an equal basis with others of your age?
☐ Yes ☐ No

Have you missed any days from work due to this accident?
☐ Yes ☐ No How many? _____

Since your injury, your symptoms are:
☐ Improving ☐ Getting worse ☐ Same

Was anyone else in the vehicle with you? _____

Do you have Personal Injury Protection (PIP) coverage? ☐ Yes ☐ No

Auto Insurance Company Name: _____ Phone # _____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other_____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
☐ Mild ☐ Moderate
☐ Totaled

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Read-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes☐☐ No**
Were you braced for the impact? **Yes☐☐ No**
Did you have a seat belt on? **Yes☐☐ No**
Did you have a shoulder harness on? **Yes☐☐ No**

Does your vehicle have headrests? Yes☐☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? **Yes☐☐ No** Did passenger side airbags deploy? **Yes☐☐ No** Did side airbags deploy? **Yes☐☐ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes☐☐ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes☐☐ No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ☐ Mild ☐ Moderate ☐ Totaled
Did police show up at the scene? **Yes☐☐ No**
Was an accident report filled out? **Yes☐☐ No**

10. After the accident:

Check off your symptoms right after and a few days following:
☐ Headache ☐ Dizziness ☐ Mid back pain ☐ Cold hands
☐ Neck pain ☐ Nausea ☐ Low back pain ☐ Cold feet
☐ Neck stiffnes ☐ Confusion ☐ Nervousness ☐ Diarrhea
☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression
☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious
☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were X-rays done? Yes☐☐ No **Was lab work done?** Yes☐☐ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ☐ Cervical Collar ☐ Ice **Other:**_____
Medications:_____
Follow-up instructions: _____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes☐☐ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes☐☐ No**
Did treatments benefit you? **Yes☐☐ No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes☐☐ No**
Did treatments benefit you? **Yes☐☐ No**
Last visit date: ____/____/____