# NEW PATIENT INFORMATION

For Office use Only
Patient #

Patient's First Name_____ Middle_____ Last_____ Date _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone_____

E-mail _____ Social Security # _____

Job Title _____ Work Phone # _____

Date of Birth _____ Age____ Gender ☐ Male ☐ Female Handedness? R L

Marital Status Single Married Widowed Divorced

Have you received any medical treatment since your accident? Y N

Hospital_____Cost_____

Medical Doctor _____Cost_____

Chiropractor_____Cost_____

Other_____Cost_____

_____

_____

_____

_____

# SYMPTOMS

**CIRCLE ALL YOU COMPLIANTS**

1. **DO YOU HAVE LACERATIONS, CUTS OR BRUISING?:**
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
   g. Other: _____

2. **HEAD INJURIES:** (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Problems learning new things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in Sexual Functioning
   dd. Nausea / Vomiting
   ee. Change of personality
   ff. Wanting to be alone
   gg. Mood swings
   hh. Sadness
   ii. Agitation
   jj. Anger
   kk. Helplessness
   ll. Reduce confidence
   mm. Apathy
   nn. Irritability
   oo. Sleepiness
   pp. Frustration
   qq. Impatience
   rr. Other head related issues_____

3. **JAW PROBLEMS:**
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side

4. **NECK INJURIES:**
   a. Neck pain
   b. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   e. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   f. Neck pain that causes headaches
   g. Neck spasms or shoulder spasms
   h. Popping, clicking or clunking sound with neck movement

5. **SHOULDER INJURIES**
   a. Shoulder pain LEFT RIGHT BOTH
   b. Shoulder pain with movement L R BOTH
   c. Shoulder spasms LEFT RIGHT BOTH
   d. Sharp shoulder pain

e. Dull shoulder pain
f. Achy shoulder pain
g. Pins and needles shoulder pain
h. Shoulder pain that radiates or shoots pain into arm
i. Other:_____

6. **UPPER ARM PAIN:** RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other _____

7. **ELBOW PAIN:** RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other_____

8. **FOREARM:** RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other_____

9. **WRIST PAIN:** RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other_____

10. **HAND PAIN:** RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other _____

11. **UPPER AND/OR MID BACK PAIN:**
    a. Upper or mid back pain
    b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
    c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
    d. Upper or mid back spasms

12. **LOW BACK PAIN:**
    a. Low back pain
    b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    d. Low back spasms

13. **PELVIC OR SACRAL PAIN:**
    a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    c. Sacral pain (tail bone)
    d. Coccygeal or coccyx (tail bone) pain

14. **HIP PAIN:** RIGHT LEFT BOTH
    a. Hip pain
    b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

15. **UPPER LEG PAIN:** RIGHT LEFT BOTH
    a. Upper leg pain that radiates to knee
    b. Upper leg spasms

16. **KNEE PAIN:** RIGHT LEFT BOTH
    a. Knee pain that radiates to calf
    b. Knee pain that radiates to calf and ankle
    c. Knee pain that radiates to calf, ankle and foot

17. **ANKLE PAIN:** RIGHT LEFT BOTH
    a. Ankle pain that radiates to foot
    b. Ankle and foot pain

18. **FOOT PAIN:** RIGHT LEFT BOTH

19. **CHEST PAIN**

20. **STOMACH PAIN**

21. **OTHER SYMPTOMS:**

_____
_____
_____
_____

## NECK PAIN

☐ I have had **FUNCTIONAL DIFFICULTIES** because of NECK PAIN in the past 7 days

Describe how NECK PAIN is affecting your normal daily activities_____
_____
_____

**EXACERBATING FACTORS** (Check all below that make your NECK hurt more)

☐ Laying on pillow ☐ Turning neck ☐ Looking up ☐ Looking Down ☐ Combing hair

☐ Computer at work ☐ Computer at home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your neck hurt _____
_____
_____

**ALLEVIATING FACTORS** (Check all below that make your NECK feel better)

☐ Doctor treatments Helps for _____ Hours Days Weeks Months

☐ Medications Helps for _____ Hours Days Weeks Months

☐ Home Exercises Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

## UPPER AND/OR MID BACK PAIN

☐ I am having **FUNCTIONAL DIFFICULTIES** because of UPPER AND/OR MID BACK PAIN in the past 7 days.

Describe how UPPER AND/OR MID BACK PAIN is affecting your normal daily activities _____

**EXACERBATING FACTORS** (Check all below that make your UPPER AND/OR MID BACK hurt more)

☐ Laying in bed ☐ Sitting ☐ Bending ☐ Twisting ☐ Lifting ☐ Dressing

☐ Computer at work ☐ Computer at home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your UPPER AND/OR MID BACK hurt) _____

**ALLEVIATING FACTORS** (Check all below that make your UPPER AND/OR MID BACK feel better)

☐ In-Office Treatments Helps for _____ Hours Days Weeks Months

☐ Medications Helps for _____ Hours Days Weeks Months

☐ Home Exercises Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

## LOW BACK & PELVIS PAIN

☐ In my Low Back or Legs, **WEAKNESS, STUMBLING, BUMPING INTO THINGS** in the past 7 days

☐ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK AND/OR PELVIS PAIN in the past 7 days.

Describe how LOW BACK PAIN is affecting your normal daily activities _____

**EXACERBATING FACTORS** (Check all below that make your LOW BACK AND/OR PELVIS hurt more)

☐ Laying in bed ☐ Sitting ☐ Bending ☐ Twisting ☐ Lifting ☐ Pushing/Pulling

☐ Computer at work ☐ Computer at home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your LOW BACK AND/OR PELVIS hurt) _____

**ALLEVIATING FACTORS** (Check all below that make your LOW BACK AND/OR PELVIS feel better)

☐ In-Office Treatments Helps for _____ Hours Days Weeks Months

☐ Medications Helps for _____ Hours Days Weeks Months

☐ Home Exercises Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

Serenity Chiropractic & Family Wellness Center
2340 E. Trinity Mills Road, Suite 225
Carrollton, Texas 75006

**Assignment of Benefits: Assignment of Cause of Action: Contractual Lien**

The undersigned patient and / or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Serenity Chiropractic & Family Wellness Center, the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me / us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician / facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Serenity Chiropractic & Family Wellness Center, and to send all checks to 2340 E. Trinity Mills Road, Suite 225, Carrollton, Texas 75006.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable to Serenity Chiropractic & Family Wellness Center, and to send any and all checks to 2340 E. Trinity Mills Road, Suite 225, Carrollton, Texas 75006.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician / facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician / facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account or forwarded to my / our address upon request in writing to the physician / facility named above.

REJECTION IN WRITING: I hereby authorize the physician / clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider / clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely
Manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician / clinic named above, and to send any and all checks or financial instruments to 2340 E. Trinity Mills Road, Suite 225, Carrollton, Texas 75006.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he / she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician / facility immediately. I understand that failure to do so may jeopardize my case.

_____ _____

Signature of Patient Date