Texas Health & Wellness
9201 FM 1488 Suite 230
Magnolia, TX 77354
Dr. Chad Everett, D.C

Last Name_____ First Name_____ Sex M F Date_____

Address_____City_____State_____ Zip_____

*We will provide a complementary reminder of your appointments. Please check the box next to the method you would like to be contacted by. Your phone number and/or email **will not** be used for any other purposes other than appointment reminders!*

□ Phone (_____) _____ □ Email _____ Date of Birth ____/____/_____

Referred by_____

Occupation_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

1. Primary reasons for seeking chiropractic care: _____

2.
Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your current complaint: _____

_____

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4. Past Health History:

A. Previous illnesses you've had : _____

_____

B. Previous injury or trauma: _____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication Reason for taking

_____ _____

_____ _____

_____ _____

E. Surgeries:

Date Type of Surgery

_____ _____

_____ _____

_____ _____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

_____ _____

_____ _____

_____ _____

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

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6. Social and Occupational History

A. Job description (driving, desk work, standing):_____

B. Recreational activities: _____

C. Lifestyle (daily stress level, hobbies, diet):_____

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week

What activities? □ Walking, □ Running, □ Weight Training, □ Cross Fit, □ Cycling, □Yoga, □ Pilates, □ Swimming, □ Golf

Do you smoke? Yes No □ Cigarettes □ Cigars □ Recreational Drugs How much / day? _____

Do you drink alcohol? Yes No □ Beer □ Wine □ Liquor How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

7. Exam, X-ray and Consent to Care:

Dr. Everett will perform an exam, in order to determine how your body is currently functioning. A more detailed exam will be performed on your effected area you listed as your chief complaint. Based off your history and exam, x-rays may be necessary prior to treatment. If so, Dr. Everett will explain why. *Please notify Dr. Everett, D.C. and/or Staff if you are pregnant or think you may be possibly pregnant.* Any abnormalities found during the exam and/or x-rays will be discussed in detail, making sure you understand what your current status is.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with Texas statutes.

Patient or Guardian Signature _____Date_____

Doctors Signature _____ Date _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.
Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.
It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.
I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Witness Name: _____Signature:_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____Medical Record No._____
Address: _____

Facility Name:Texas Health & Wellness

I have been given a chance to read a copy of Texas Health & Wellness' Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Texas Health & Wellness has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Texas Health & Wellness web site at www.texashealthwellness.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.
1. If the resident or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:
_____
_____
2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the Acknowledgement:
_____
_____
Completed by:
_____ _____
Signature of Facility Representative Date

_____
Print Name
File original in patient's Business Office Record.