SOUTH TEXAS SPINE & JOINT INSTITUTE

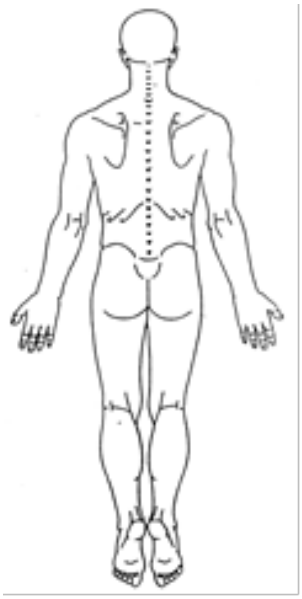
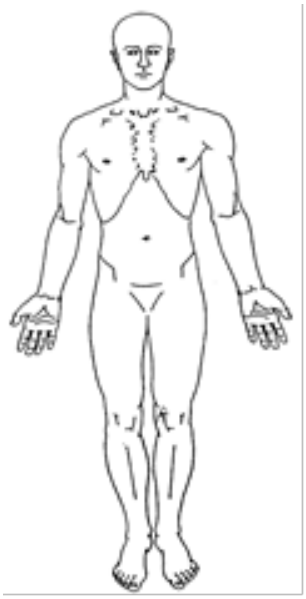
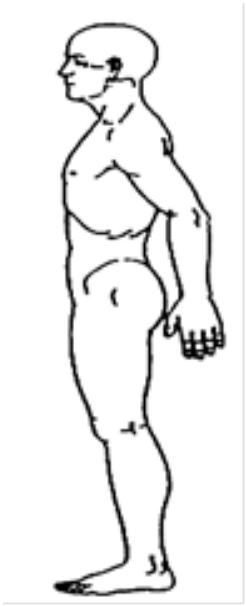
NEW PATIENT INTAKE

Name: _____
Address: _____
City / State / Zip: _____
Home # _____ Work # _____
Cell # _____ Email _____
Sex: M / F Date of Birth: _____ Age: _____
Social Security # _____
Marital Status: S / M / D / W / SEP
Emergency Contact: _____
Emergency Contact Phone # _____
How did you hear about us? _____
Email address: _____

Date: _____
Employer: _____
Occupation: _____
Address: _____
City / State / Zip: _____
Telephone: _____
Insurance Company: _____
Insurance Phone # _____
Policy Holder: _____
Policy Holder SS # _____
Who referred you? _____

PLEASE CIRCLE & MARK ALL COMPLAINT AREAS

Head / Face	Thigh	Shoulder blade	Chest	Skin	Blood
Neck	Knee	Arm	Abdomen	Ears	Heart
Mid-back	Ankle	Elbow	Groin	Eyes	Gastro-intestinal
Lower back	Foot / Toes	Wrist	Breast	Nose	Genital-urinary
Hip / Glutes	Shoulder	Hand / Fingers	Lung	Mouth / Throat	Ob / Gyn
Poor Nutrition	Body Fat	Lack of Energy	Hormones		

PLEASE CIRCLE ALL AREAS OF INTEREST

Medications	Physical therapy	Spinal Decompression	Nutritional support
Pain management	Chiropractic care	Acupuncture	Anti-aging
Injections	Rehabilitative therapy	Braces / Supports	Weight loss
Advanced pain management	Post-operative therapy	Laser therapy	Neuro-transmitters
Laboratory services			Neuropathy

PAST MEDICAL HISTORY

Please circle all current & prior history of conditions

Alcoholism	Anemia	Appendicitis	Asthma	Bronchitis	Cancer	Chicken pox
Cold sores	Diabetes	Eczema	Edema	Emphysema	Epilepsy	Thyroid disease
Gout	Heart burn	Heart disease	Hepatitis	Herpes	HIV / AIDS	High Cholesterol
Influenza	Malaria	Measles	Polio	Miscarriage	Mumps	Panic Disorder
Tingling	Pace maker	Osteoporosis	Pneumonia	Insomnia	Migraines	Multiple Sclerosis
Ulcers	Tuberculosis	Goiter	Stroke	ADHD	ADD	Rheumatic fever
Depression	Anxiety	Numbness	Hormones	Weight Control	EBV	Hypertension

Other:_____

Please list any prior traumas / symptoms / accidents within the past 2 years.

Date: _____ Description: _____
Date: _____ Description: _____
Date: _____ Description: _____
Other:_____

Please list all current medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all past surgeries.

Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____
Date: _____ Description: _____ Doctor: _____

Please circle all that apply.

Exercise level: None / Light / Moderate / Heavy / Regular / Infrequent _____
Alcohol use: None / Rarely / Socially / Regularly / Usage/Type: Qty / day: _____
Tobacco use: None / Rarely / Socially / Regulary / Usage/Type: Qty / day: _____

Who is your family physician? _____ Who was your last Chiropractor? _____

FAMILY HISTORY

Marital Status: S / M / D / Sep / W Spouses Occupation: _____ # of Children ____boys ____ girls

Please fill in all applicable sections				
Blood Relatives	Age if living	Age at death	State of health	Cause of death
Father				
Mother				
Brother (s)				
Sister (s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

ACTIVITIES OF DAILY LIVING

GENERAL		TRAVEL	HOUSEWORK	YARDWORK	HYGEINE
Walking Standing Sitting Chewing Sleeping Kneeling Climbing Stairs Reading Lifting	Swimming Playing piano Sexual intercourse Running Bending Using telephone Lying in bed Exercising Using computer	Driving Riding in car Plane trips In / Out of Auto	Doing laundry Making the bed Vacuuming Washing dishes Ironing Carrying groceries Cooking Caring for pets	Mowing the lawn Racking leaves Gardening	Combing hair Brushing teeth Shaving In / out shower / tub Dressing

Please circle all areas affected. Please list any additional areas affected not listed about

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

MVA / PERSONAL INJURY / WORK RELATED INJURY QUESTIONAIRRE

Date of accident: _____ Time of accident: _____ Location: _____

Accident description: _____

_____

_____

CONSENT TO EXAMINATION, DIAGNOSE, AND TREATMENT

By my signature, I acknowledge that all of the information provided is true and correct as to the best of my knowledge. I also, the patient, give consent and authorization to be examined and diagnosed by the doctors of the South Texas Spine & Joint Institute through examinations and / or diagnostic tests. I also, the patient, give consent and authorization to be treated. I understand that instances have been reported in certain medical journals of patients experiencing *cerebral vascular accidents (strokes)* after cervical manipulation. There has not been any correlation, to any medical certainty, of any cause or effect between cerebral vascular accident and cervical manipulation. Although the doctor(s) at this clinic feel that any incident of stroke following cervical manipulation is extremely rare, it is our policy to fully disclose this information to our patients. A stroke can cause paralysis, brain disorders, and death. This complication has NEVER occurred at this clinic. In addition, *injury to muscles, ligaments, tendons, bones, and nerves* are also possible. In the unlikely event that this should happen, it is seldom if ever life threatening. However, injuries such as these have been reported to cause severe pain and can decrease your overall functionality.

I understand this explanation and disclosure and fully accept these risks as a complication of my treatment.

_____ _____

Patient Signature **Date**