CHIROPRACTIC SPORTS AND ACUPUNCTURE

DR. JAMES CORDOBA DC
1200 LAKEWAY DRIVE, SUITE 17B
LAKEWAY, TX 78734
T: 512.608.9121 F: 888.275.9099
CHIROPRACTICSPORTSANDACUPUNCTURE.COM
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PATIENT CONSENT AND NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, and public health, research, and law enforcement activities. Any other disclosure for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name: _____

Date:_____

Thank you!

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~Welcome~

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Ph: _____ Mobile Ph:_____

Email: _____ S.S.# _____ - ____- _____

Occupation: _____ Employer: _____ DOB: ____/____/ _____

Number of children : _____

Marital Status: S M D W Spouse / Contact Name: _____ Referred by:_____

How did you find out about Chiropractic Sports and Acupuncture? _____

History of participating in Athletics: _____

Experience any motor vehicle accidents, falls, broken bones or surgeries:
_____

Alcoholic Beverages / per week:_____

Do you smoke or have you ever smoked/ how long? _____

How important is your health? _____

Diet/ Nutrition/ Water Intake per day _____

History of Headaches, Balance Issues, Vertigo, Dizziness, Joint Pain, Fatigue, Poor Sleep, Low Energy, Depression, Anxiety: _____

Family history of: Heart disease, Diabetes, Cancer, Parkinson's, Arthritis, Alzheimer's:
_____

Medications currently taking / how long: _____
Do you have any Health Goals that you would like to achieve? _____
Do you have a consistent exercise program? Please describe:_____

Females:
Are you pregnant or might you be pregnant? Y / N

Birth control: Y / N: How long/type: _____

History of painful menstrual periods: Y / N

Back Pain with menstrual periods: Y / N

Vaginal bleeding other than period: Y/ N

Other menstrual problems: _____

Hysterectomy: Y / N If Yes (Year): _____

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Patient Injury /Medical History Form

Name: _____ Date: _____

Reason for today's visit:

_____

How did injury occur (if applicable):

_____

_____

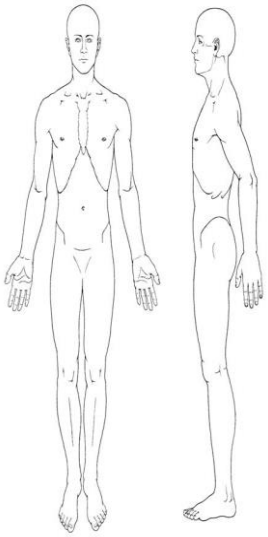
_____

_____

Please list your area of complaint from greatest to least (1-4) and circle the areas of complaint on the drawings below. Also, please rate your pain/discomfort on a scale of 1-10 where "1" is minor pain and "10" would be the most severe pain (ie the most severest pain you have ever experienced).

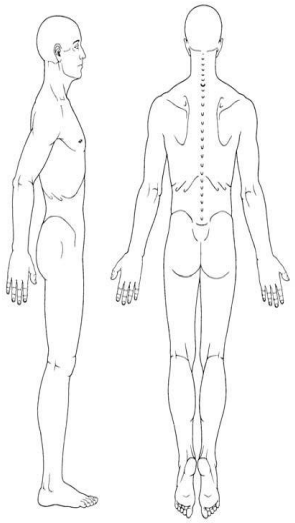
1. _____ Pain level: 1 2 3 4 5 6 7 8 9 10
2. _____ Pain Level: 1 2 3 4 5 6 7 8 9 10
3. _____ Pain Level: 1 2 3 4 5 6 7 8 9 10
4. _____ Pain Level: 1 2 3 4 5 6 7 8 9 10

Right Left



LEFT SIDE

Left Right



RIGHT SIDE

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TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

It is important that the patient understand both the objective and the method of Chiropractic. First and foremost, the goal of Chiropractic is to diagnose and treat the cause of the patient's health condition so that pain relievers, injections, muscle relaxers, and lastly, surgery might be avoided. This does not mean that this office is against the use of drugs or surgery if absolutely necessary for the well-being of the patient.

The goal of this office is to correct the subluxation or misalignment of the spinal column and/or joint. Subluxation or misalignment of one or more of the 24 vertebrae in the spinal column will cause an alteration of nerve function and interference to the transmission of mental impulses- resulting in a lessening of the body's innate ability to express its optimal health potential.

If, during the examination process or in the course of your care, we suspect any disease or encounter a health condition out of the scope of Chiropractic, we will advise you immediately and refer you to the proper health care provider.

I, _____ have read, and fully understand as well as all questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept Chiropractic care on this basis.

_____ *(signature)*
_____ *(date)*

Consent to evaluate and adjust a minor:
I, _____ being the parent or legal guardian of _____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic Care at the office of Chiropractic Sports and Acupuncture.

Name_____ Date_____ consistently taking supplements_____%

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY'S SYSTEMS

For your 1st visit-checkmark any symptom you have experienced in last 6 months. For Re-exams-checkmark symptoms you are currently experiencing.

HEADACHES
___ Base of Skull (back)
___ Side of head (Temples)
___ Frontal (above eyes)
___ Top of head
___ Entire Head
___ Migraines
___ Cluster
___ Other_____

EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ear Ache
___ Ear Infections
___ Draining
___ Itchy
___ Hearing Loss
___ Dizziness/ Vertigo
___ Excessive Ear Wax
___ Other_____

EYES
___ Burn
___ Tear
___ Ache
___ Red
___ Dry
___ Eye Film
___ Crust in morning
___ Itchy Eyes
___ Bouts of Blurriness
___ Floaters
___ Spots
___ Tired
___ Puffy
___ Stye
___ Twitching around eyes
___ Dark Circles
___ Light Bothers Eyes
___ Nearsighted
___ Farsighted
___ Other_____

SINUS
___ Nosebleeds
___ Dry
___ Drain
___ Stuffy/ plugged up
___ Sneeze frequently
___ Smell Loss
___ Taste Loss
___ Post nasal drip...circle color:
white/yellow/green/gray
brown/blood/blood/clear
___ Other_____

MOUTH/ THROAT/ IMMUNE
___ Blisters
___ Canker Sore
___ Bad Breath
___ Bleeding gums
___ Receding gums
___ Teeth Health Problems
___ Dry Mouth
___ Swelling of Glands
___ Difficulty Swallowing
___ Sore Throat
___ Hoarseness
___ Fever
___ Chills

CHEST
___ Tension
___ Tight
___ Pressure
___ Heaviness
___ Congestion
___ Chest Pain
___ Sternal Pain
___ Sharp Heart Pain
___ Palpitations-Heart Skip/Flutter
___ Heart Racing
___ Heart Slowing down
___ Mitral Valve Prolapse
___ Murmur
___ Other_____

SHORTNESS OF BREATH
___ Constant
___ Upon Exertion
___ Wheeze
___ Air Hunger
___ Asthma
___ Frequent Sighs
___ Emphysema
___ Other_____

STOMACH
___ Heartburn
___ Indigestion
___ Stomach Aches
___ Stomach Cramps
___ Nausea/ Queasy
___ Bloat after Eat
___ Gas/ Flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
___ Other_____

BOWELS
Bowel Movements_____ Per day
___ Regular
___ Incomplete
___ Skip days _____ per (week/month)
___ Sluggish bowels every ___ days
___ Cramps in Abdomen
___ Taking Laxatives
___ Using Suppositories
___ Enemas
___ Colonics
___ Bulky
___ Pain with Bowel Movements
___ Irritable Bowel Syndrome
___ Chrons
___ Colitis
___ Other_____

FECAL CONSISTENCY
Color feces light or dark _____
___ Normal
___ Soft
___ Hard
___ Pebbles
___ Dry
___ Ribbon-like
___ Mucous
___ Diarrhea
___ Constipation
___ Other_____

HEMORRHOIDS

URINATION
_____times per day-frequency
___ Urinate at night ____ per night
___ Urgency
___ Burning
___ Pain
___ Odor
___ Spasm
___ Leakage
___ Urinary Tract Infection
___ Incontinence
___ Kidney Troubles
___ Other_____

ENERGY
___ Low
___ Variable
___ Normal
___ High
___ Slow to start in the morning
___ Low Energy after meals
___ Energy Crash_____am/pm
___ Other_____

SLEEP
Quality (poor/fair/good/great)
____ Hours in bed
____ Hours asleep
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Interrupted ___ per night
___ Crave Sleep during day
___ Awaken Suddenly (Jolt)
___ Don't Remember Dreams
___ Nightmares
___ Night sweats
___ Restlessness
___ Sleep Apnea
___ Other_____

EMOTIONS
___ Stressed
___ Sad
___ Grief
___ Depression
___ Moodiness
___ Frustrated
___ Irritable
___ Angry
___ Worrisome
___ Nervous
___ Anxiety
___ Panic
___ Cry
___ Fear
___ Shame
___ Other_____

APPETITE/ DIET
___ Low Appetite
___ Normal Appetite
___ High Appetite
___ Starch (pasta/bread/potatoes/rice)
___ Sweets
___ Chocolate
___ Coffee ____cups/ day
___ Caffeinated Tea ____cups/day
___ Beer ____per week
___ Wine____per week
___ Juice ____per week
___ Soda ____per week

MEMORY
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Concentrating
___ Other_____

LIBIDO/ SEXUALITY
___ Flat
___ Low
___ Normal
___ Erectile Dysfunction (men)
___ Orgasm Quality (poor/ good/ great)
___ Other_____

SKIN/ HAIR/ NAILS
___ Skin Rash
___ Acne
___ Dry Skin
___ Itchy Skin
___ Patches skin look different
___ Cellulite
___ Nails (weak/ spots/ lines)
___ Hair loss
___ Limp Hair
___ Other_____

CRAMPS/ ACHES/ RESTLESS
___ Cramps (legs/feet/arms/hands)
___ Aches (legs/feet/arms/hands)
___ Restless (legs/feet/arms/hands)
___ Other_____

PAIN/ STIFFNESS/ SWELLING NUMBNESS/ TINGLING
___ Facial
___ Neck
___ Trapezius
___ Upper Back
___ Shoulders
___ Arms
___ Elbows
___ Wrist
___ Hand
___ Mid Back
___ Low Back
___ Sacral Iliac
___ Hips
___ Buttocks
___ Legs
___ Sciatica
___ Knees
___ Ankles
___ Feet
___ Other_____

For Men Only: PROSTATE
___ Burn
___ Achyness
___ Pain
___ Restriction
___ Dribbling
___ Emission
___ Swelling
___ Other_____

List Your Primary Concerns in order of importance to you:
1)_____

MENSES (women only)
Last Menstrual Period_____
Length of Menses_____
___ Regular
___ Irregular
___ Early (less than 28 days)
___ Late (more than 28 days)
___ Skip
___ Birth Control Pill
___ Flow (heavy/ moderate/ light)
___ Clotting/ Spotting
___ Cramps (mild/ mod/ severe)
___ Low Abdominal Puffiness
___ Fluid Retention Face
___ Fluid Retention Hands
___ Fluid Retention Feet
___ Tired during cycle
___ Acne (pre/post)
___ mood swings/irritable/depression
___ Breast Tender around cycle

BREASTS (women only)
___ Breast Tender constant
___ Breast Feeding
___ Fibrosis
___ Lump
___ Discharge
___ Prosthesis
___ Augmentation Surgery
___ Reduction Surgery
___ Pathology
___ Other_____

VAGINA (women only)
___ Burn
___ Itch
___ Dry
___ Pain
___ Blood
___ Discharge
- Clear
- White
- Yellow
- Green
- Brown
- Odor
___ Other_____

MENOPAUSE (women only)
___ Natural
___ Surgical (partial/complete)
___ Hormones
___ Patch
___ Hot Flashes
___ Skin Crawling
___ Cherry Hemangiomas
___ Facial Hair
___ Hair growing up towards belly button
___ Dark Nipple Hair
___ Other_____

For Doctor's Use
___ Frenular Cyst
___ Cracks in Tongue
___ Allergy Patches Tongue
___ Geographic Tongue
___ Red Spots Tongue
___ Swollen Tongue
___ Color Tongue_____
___ Dark Veins Tongue
___ Coated Tongue (mild/mod/severe)

___	Cold/ sweaty hands or feet	___	Swollen	___	Artificial Sweeteners		___ Ear Creases (Rt/ Lt) mild/mod/severe)
___	Cough (dry/productive)	___	Burning	___	Eat a lot of Spicy Foods	2)	Weight ____(+/-___lbs) overall(+/-___)
___	Environmental Allergies	___	Blood	___	Ice Cream		Height_____
___	Upper Respiratory Infection	___	Distended			3)	Pulse_____BP:(_____/_____)
___	Frequent Colds/ Flu	___	Itchy		**EXERCISE**		saliva pH_____ Urine pH_____
___	Chronic Bronchitis	___	Stingy		Cardiovascular ____ times/ week	4)	Allergies_____
	Other_____	___	Achy		Weight Train ____times/per week		Current Meds:_____