Welcome to
LONESTAR CHIROPRACTIC

About You

Name:_____ Today's Date: _____/_____/_____

What do you prefer to be called: _____

□F □M Height _____Weight _____Blood Pressure_____ Preferred Language_____

Birthday: ___/___/____ Age: _____ Race: _____

Home Address: _____ City: _____ State:___Zip:_____

**Cell #: (_____) _____-_____ Home #: (_____) _____-_____

**email:_____

****Your phone numbers or email will NEVER be sold or shared.**

To which of the above would you like your appointment reminders sent?

□Email or □Text Msg

WHO IS YOUR CELL PHONE PROVIDER? AT&T, Verizon, Sprint, T-mobile, Other:_____

How soon before each visit should we send it? □ 1 hr. □2 hrs. □ 4 hrs. □ 24 hrs.

Occupation: _____ Phone #: (____) ____-_____

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

Spouse's Name: _____

Referred To This Office By: _____

Who Is Responsible For Your Bill: □You □Spouse □Workers' Comp. □ Parent

□Auto Insurance □ Medicare □ Personal Health Insurance

***If an Auto accident please provide:** Date of Accident: _____Insurance: _____

Contact person: _____ Phone #: _____ Claim # _____

Emergency Contact: Name _____ Relation: _____ #: (____) _____-_____

Who is your Medical Doctor? _____ #: (___) ____-_____

Reason for visit

Have you been to a Chiropractor before? _____If yes, tell me about your experience(s).

If no, tell me what you have heard about Chiropractic _____

_____

What is your chief complaint? _____

When did this condition begin? ___/___/____

Has this or similar conditions occurred before? □Yes □ No

Is condition: □ Job Related □Auto Accident □ Home Injury □ Fall □ Other_____

Is condition getting worse? □ Yes □ No □ Constant □ Comes and goes

Does it interfere with your(Circle One): Work, Sleep, Recreation or Daily Routine

If so, please explain:_____

Rate your pain on a scale from 1-10 (10=most severe pain ever) _____

Does anything make your condition feel better? _____

What aggravates your condition? _____

Have you been seen by any other Doctors for this condition? □ Yes □ No

Who?_____ When? _____

What treatment have you already received for your condition? □ Medication

□ Surgery □ Physical Therapy □ Chiropractic □ None □ Other _____

Health History

Please list any other serious medical condition(s) you or your family have ever had:_____
_____
What medications are you taking? _____
List anything you may be allergic to (including meds):_____
List any serious accidents you've been involved with, including dates:_____
_____
If you go too long without eating does it bother you? YES or NO
Do you get headaches, nausea, irritability, weakness, etc if you don't eat? YES or NO
How would you rate your energy level? GOOD OK BAD
Do you feel it is as good as it should be? YES or NO Do you have a sweet tooth? YES or NO
Do you have trouble getting to or staying asleep? YES or NO
What different type of adrenal stimulants do you consume and how much - coffee, sodas, tobacco, alcohol? _____
Do you smoke ? Everyday Sometimes Used to smoke Never smoked
Do you usually wear sunglasses when outside? YES or NO
Do you occasionally get light headed or see stars when you get up from the floor or hop out of bed quickly? YES or NO
How much stress do you feel you are under? SEVERE MEDIUM MILD
Are you a Type A or a perfectionist? YES or NO Do you have acid reflux? YES or NO
Do you feel your digestion is good? YES or NO Do you drink soda? YES or NO DIET?**For Women:** Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ YES NO How far along? _____ Nursing? ☐ YES ☐ NO

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made. The undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing fifty percent (50%) of the principle balance if the account is referred to a collection agency or attorney. This additional amount is in recognition of the costs associated with said collection action processes.
- I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named, for whom I am legally responsible) by Dr. Benjamin Higbee and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Benjamin Higbee, including those working at the same building whether signatories to this form or not.
- I have had an opportunity to discuss with Dr. Higbee and/or other office personnel the nature and purpose of chiropractic adjustments and procedures. I understand that the results are not guaranteed.
- I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest.
- I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and by signing below I agree to the above mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient (or Responsible person) Signature _____ Date ___/___/____

Office Signature _____ Date __/ ___/ _____