Key Family Wellness Chiropractic Center

2803 W. Oak Street

Palestine, Texas 75801

903-729-4325

Welcome to our practice. We are happy that you have chosen us to provide you and your family with quality chiropractic care. As we welcome you we would also like to take this time to notify you that there are often charges in our office that are not covered by insurance. The non-covered charges are as followed:

1. Nerve scans (The cost for the nerve scan is $50.00. This is a required scan for all new patients. A nerve scan is required every 12th visit to ensure you are progressing during your treatment)
2. Ice packs (The cost of Ice Packs are $20.00) Ice packs are sold only as an as needed item.
3. Insurance Deductible (If you have not met your required deductible you will be responsible for all charges incurred in our office. These charges are to be paid at the time service.)
4. Co-payments (Most insurance companies require insured patients to pay a co-payment. This charge will be due at the time services are rendered.)
5. Unpaid premiums-(If our office is presented with a non-valid insurance card or a card that is later denied due to non-payment of premiums, you will be responsible for the unpaid charges in our office.
6. Payment is due at the time services are rendered. There could still be a remaining balance when the explanation of benefits is provided to our office by your insurance company. Any differences will be your responsibility.

Please note that is the patient's responsibility to verify that we are in network provider for your insurance plan, as well as, making sure that chiropractic is a covered benefits. If you have any questions or concerns please feel free to ask.

_____	_____	_____
Patient Print	Patient Signature	Date
_____	_____	_____
Witness Print	Witness Signature	Date

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date: / /
SS#: - -	DOB: / /	Sex: ◯ M ◯ F
Marital Status:	# of Children:	Occupation:
Street Address:		Height: ft in
City:	State: Zip:	Weight: lbs
Email:	Cell Phone: - -	Other Phone: - -
Emergency Contact:	Emergency Relation:	Emergency Phone: - -

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? ◯ Yes ◯ No

- If yes, please name them and their specialty:

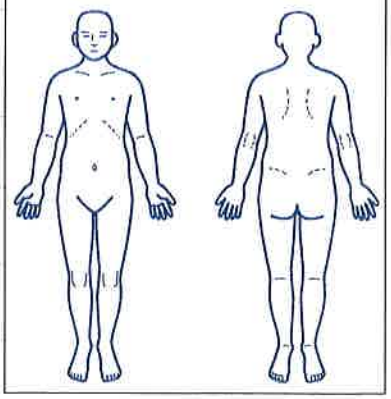
Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.

X= Current condition O= Past condition



Have you received care for this problem before? ◯ Yes ◯ No

- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____

2. _____

3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ◯ Resolve existing condition(s) ◯ Overall wellness ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ◯ Yes ◯ No
- If yes, please explain:

Notable childhood injuries? ◯ Yes ◯ No If yes, please explain:

Youth or college sports? ◯ Yes ◯ No If yes, list major injuries:

Any auto accidents? ◯ Yes ◯ No If yes, please explain:

Exercise Frequency? ◯ None ◯ 1-2x per week ◯ 3-5x per week ◯ Daily
What types of exercise?

How do you normally sleep? ◯ Back ◯ Side ◯ Stomach Do you wake up: ◯ Refreshed and ready ◯ Stiff and tired

Do you commute to work? ◯ Yes ◯ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: __/__/____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		PAST PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	☐ ☐ Epilepsy & Seizures
		☐	☐	Ear & Sinus Infections	☐ ☐ Sensory & Spectrum
		☐	☐	Allergies & Congestion	☐ ☐ ADD / ADHD
		☐	☐	Immune Deficiency	☐ ☐ Focus & Memory Issues
		☐	☐	Headaches & Migraines	☐ ☐ Anxiety & Stress
		☐	☐	Vertigo & Dizziness	☐ ☐ Balance & Coordination
		☐	☐	Sore Throat & Strep	☐ ☐ Speech Issues
		☐	☐	Swollen Tonsils & Adenoids	☐ ☐ TMJ / Jaw Pain
		☐	☐	Vision & Hearing Issues	☐ ☐ Stiff Neck & Shoulders
		☐	☐	Low Energy & Fatigue	☐ ☐ Depression
		☐	☐	Difficulty Sleeping	☐ ☐ High Blood Pressure
		☐	☐	Paln, Numbness & Tingling in Arms to Hands	☐ ☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	☐ ☐ Bronchitis & Pneumonia
		☐	☐	Chronic Colds & Cough	☐ ☐ Functional Heart Conditions
		☐	☐	Asthma	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	☐ ☐ Indigestion & Heartburn
		☐	☐	Jaundice	☐ ☐ Stomach Pains & Ulcers
		☐	☐	Fever	☐ ☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	☐ ☐ Allergies & Eczema
		☐	☐	Hyperactivity	☐ ☐ Skin Conditions / Rash
		☐	☐	Chronic Fatigue	☐ ☐ Kidney Problems
		☐	☐	Chronic Stress	☐ ☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	☐ ☐ Sciatica & Radiating Pain
		☐	☐	Chrohn's, Colitis & IBS	☐ ☐ Lumbopelvic / SI Joint Pain
		☐	☐	Diarrhea	☐ ☐ Hamstring Tightness
		☐	☐	Bed-wetting	☐ ☐ Disc Degeneration
		☐	☐	Bladder & Urination Issues	☐ ☐ Leg Weakness & Cramps
		☐	☐	Cramps & Menstrual Issues	☐ ☐ Poor Circulation & Cold Feet
		☐	☐	Cysts & Endometriosis	☐ ☐ Knee, Ankle & Foot Pain
		☐	☐	Infertility	☐ ☐ Weak Ankles & Arches
		☐	☐	Impotency	☐ ☐ Lower Back Pain
		☐	☐	Hemorrhoids	☐ ☐ Gluten & Casein Intolerance

Patient Name: _____ Date: ___/___/___

ARE YOU AWARE THAT
Doctors of Chiropractic work with the nervous system? □ YES □ NO
The nervous system controls all bodily functions and systems? □ YES □ NO
Chiropractic is the largest natural healing profession in the world? □ YES □ NO

MEDICATIONS THAT YOU TAKE	
□Cholesterol Medication	□Blood Pressure Medicine
□Anti-Depressant	□Blood Thinners
□Sleep Aid	□Pain Killers and Aspirin
□Muscle Relaxers	□Other:
□Insulin	□Other:

GOALS FOR YOUR CARE
People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.
□ **Relief care:** Symptomatic relief of pain or discomfort.
□**Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
□**Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.
□**I want the doctor to select the type of care appropriate for my condition.**
Would you like to know more about:
□Proper nutrition, meal planning, vitamins and supplements
□Proper exercise routines and techniques
□How to deal with lifestyle stress

Your Wellness Quotient is a number on a scale from 0-200 and is based on your current lifestyle choices-how and what you are eating, your sleep and exercise habits, etc.

INSTRUCTIONS: On the chart below, mark an "x" where you think your current Wellness Quotient is and mark an "O" where you want it to be.

What's your Wellness Quotient? Where do you want it to be?				
0-50 Very Challenged	50-75 Challenged	75-100 Transition	100-125 Good	125+ Excellent

TOWARDS ILLNESS ← **WHERE ARE YOU MOVING** →TOWARDS WELLNESS

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Print name_____ **Signature**_ ____ _____ **Date**_____

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I, _____ understand that as part of my healthcare (or my minor child's healthcare) this practice originates and maintains health records describing health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment

A means of communication among the many health professionals who contribute to my care

A source of information for applying my diagnosis and surgical information to my bill

A means by which a third-party can verify that services billed were actually provided

A tool for routine healthcare operations such assessing quality and reviewing the competence of healthcare professionals.

I understand and have provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing the consent. I understand that I have the right to request restriction as to how my healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

Signature (parent/guardian if minor) Date

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Consent for Treatment:

I hereby authorize Key Chiropractic to administer the treatment as may be deemed necessary or advisable in the diagnosis and treatment of named patient.

Release of Information: I authorize Key Family Wellness Chiropractic Center to obtain and/or release any medical information requested by representatives of local, state or federal agencies, insurance companies, workmen compensation carriers, the patients or guarantor's employer, or other organization's or entities as me be required for payment of claim or treatment of patients.

Financial Responsibility Initial

I understand that Key Family Wellness Chiropractic Center will, as a courtesy, file with my insurance. ____

I understand that all co-pays, deductibles, etc. are due before services are rendered. ____

I understand and agree that I am responsible for the balance of my account for any professional services rendered. I have read all the information on these sheets and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in status of the above information. ____

Signature (parent/guardian if minor) Date

Key Family Wellness Chiropractic Center Photo Release

I grant Key Family Wellness Chiropractic Center and its employees the right to take photographs of me with connection to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Key Family Wellness Chiropractic Center may use such photograph of me and for any lawful purpose, including such purposes as publicity, illustration, advertising, and web content.

I am at least 18 years of age and have read and understand the above:

Patient Printed Name: _____

Signature_____

Print name_____

If under 18 years of age the legal guardian or parent has read and understands the above:

Signature_____

Print name_____

Relationship to patient _____

Key Chiropractic

The Nature of Chiropractic Manipulation:

The primary treatment used by chiropractic doctor includes joint mobilization; physical modalities, i.e., cryotherapy, hydoculation, Interferential, sine wave, ultrasound, traction, rehabilitative exercises, stretching and education. The doctor of chiropractic will use his/her hands to mobilize your joints and or soft tissue in such a way as to restore motion to restricted areas of movement. This motion may cause audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

The Nature of Physical Medicine:

When physical medicine is applied to your area of complaint, you may experience a "tingling" or "pin-prick" feeling with electrical modalities or heat/cold with application of treatment as the damaged/injured soft tissue responds to the therapy, often described as soreness similar to that when one first begins an exercise program.

The Material Risks Inherent In Chiropractic Treatment:

As with any health care procedure, there are certain complications, which may arise during the chiropractic treatment. Those complications may include:

Fracture, disc injury, dislocation, muscle strain, Horner's Syndrome diaphragmatic paralysis, cervical myelopathy, and costovertebral sprain/separation. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious sequelae including stroke.

The Probability of Risk Occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone. Stroke has been the subject of tremendous disagreement with the medical community with one prominent authority saying that there is at most a one in 3-trillion chance of such an outcome. Since even the risk of such complications should be avoided, we take a history, employ test in our examination and x-ray which are designed to identify the injured area and indicate those who may be susceptible to this type of injury. The other complication is also generally described as "rare".

Other Treatment Options

Other treatment options for your condition may include:

- Do nothing-remain untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer postponed. The probability that non-treatment will complicate a later rehabilitation is very high.
- Self-administer over-the counter medications.
- Medical care with prescription drugs such as anti-inflammatory and/or muscle relaxants.
- Hospitalization with traction and possible surgery.

Investigate the complications inherent with each alternative, some of which may be quite common and severe.

Do not sign until you have read and understand the above.

PLEASE CHECK THE APPRORIATE BOX AND SIGN BELOW

I have read and understand [ ] or have not read [ ] the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the recommended treatment. Having been informed of the risks, I hereby give my consent to that treatment on me or on the person named below for which I am legally responsible for present and future conditions.

Patient Print	Patient Signature	Date
Witness Print	Witness Signature	Date