southlake
PHYSICAL MEDICINE

Email completed forms to: info@southlakephysmed.com

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City State Zip

Phone # (H) _____ (W) _____ (Other) _____

Employer: _____ Occupation: _____

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Emergency contact:Name: _____ Relation: _____ Phone #: _____

Phone #:(H) _____ (W) _____

How did you hear about our practice? _____

Insurance Information

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____
Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Southlake Physical Medicine/Chiropractic Care Center, LLC (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

X _____ _____
Signature of Patient/Guardian Date

X _____ _____
Witness (Office Staff) Date

NAME:_____DOB:_____Age:_____Date of Exam:_____

Please tell us what brings you in today?_____

Please check to indicate if you are currently or have ever experienced any of the following conditions:

Medical
- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Diabetes
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Hepatitis
- ❑ Kidney Disease
- ❑ Loss of Memory
- ❑ Measles
- ❑ Mononucleosis
- ❑ Nausea
- ❑ Pneumonia
- ❑ Polio
- ❑ Psychiatric Care
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Diabetes

Please list all medical conditions
NOT Listed elsewhere on this form:

Metabolic/Nutritional
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Cold Sores
- ❑ Bleeding Disorders
- ❑ Constipation
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Bulimia
- ❑ Cold Feet/Hands
- ❑ Dizziness
- ❑ Fatigue
- ❑ Goiter
- ❑ Weight gain
- ❑ Gout
- ❑ Hair Loss
- ❑ Headaches
- ❑ Insomnia
- ❑ Liver Disease
- ❑ Light Bothers Eyes
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
- ❑ Sudden Weight Loss
- ❑ Ulcers
- ❑ Food cravings
- ❑ Vitamin D deficiency
- ❑ Abdominal Pain

Physical
- ❑ Arthritis
- ❑ Neck Pain/Stiffness
- ❑ Mid Back pain/stiffness
- ❑ Low Back pain/stiffness
- ❑ Sciatica
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot pain
- ❑ Numbness/tingling
- ❑ Wrist pain
- ❑ Shoulder pain

Hormonal
- ❑ Depression
- ❑ Low Body Temp
- ❑ Migraines
- ❑ Miscarriage
- ❑ Nervousness
- ❑ Osteoporosis
- ❑ Prostate Problems
- ❑ Breast Lump
- ❑ Suicide Attempt
- ❑ Vaginal Infections
- ❑ Low libido
- ❑ Oral contraceptive use
- ❑ Thyroid Problems

Cardiology
- ❑ Ankle Swelling
- ❑ Arm/Hand Pain
- ❑ Cold Sweats
- ❑ Chest Pain
- ❑ Fainting
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Pacemaker
- ❑ Varicose Veins
- ❑ Carotid artery blockage
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Low magnesium
- ❑ Low potassium
- ❑ Stroke
- ❑ Anemia

- ❑ Diabetes
- ❑ PCOS
- ❑ Fibroids
- ❑ Breast Cancer
- ❑ Prostate cancer
- ❑ Triglycerides >300

INITIAL INTAKE

NAME: _____

Are you currently under drug and/or medical care? ❑ Yes ❑ No Who is your primary care Dr? _____

Please list all medications: (**Be sure to include dosage and frequency**) _____

_____

Are you on any anti-inflammatory meds? (Aleve, Naproxen, Motrin, Ibuprofen, Celebrex, Meloxicam, Mobic, Voltaren, Diclofenac)

Other: _____ Do you take blood thinners (Coumadin, Plavix, Asprin, Xarelto, Eliquis, Pradaxa)? _____

Supplements (vitamins/herbs/minerals): _____

Allergies: _____

WOMEN ONLY: Date of LMP: _____ ***Any possibility of pregnancy: YES or NO***

Surgical History: (Please note ALL joint replacement surgeries!)

Surgeries and/or hospitalizations (**type & date**): _____

_____

Family History: Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Social History:
Intake of following: Cigarettes ____ packs/day Alcohol _____ drinks/week Caffeine _____ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, and agree that all disputes will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Signature: _____ I have read and understand the above consent form.

Date: _____