**PATIENT INFORMATION**

Name: ______________________ Date: ______________

Age: ________ Date of Birth: ____________ S.S#: ____________ Email: ______________

Address: ____________________________________________
Street Name & Number City State Zip
Home Phone #: ____________ Cellular #: ____________ Wk #: ____________
Marital Status: S M W D

**EMPLOYMENT INFORMATION**
Employer Name: ______________________ Occupation: ______________________

Address: ____________________________________________
Street Name & Number City State Zip

**INSURANCE INFORMATION**
Private Ins. (group):______________________ Auto Accident______________________
Have you engaged an attorney in connection with the present illness/accident? ☐ No ☐ Yes, If yes Attorney Name:______________________ Phone #: ______________________

**INSURANCE COMPANY**
Name:______________________Phone #:______________________
Policy#:______________________Group #:______________________
Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative ____________
Policy Holder: Name:______________________DOB: ____________S.S#: ____________
Employer Name: ______________________Phone #:______________________

**SECONDARY INSURANCE COMPANY INFORMATION**
Name:______________________Phone #:______________________
Policy#:______________________Group #:______________________
Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative ____________
Policy Holder: Name:______________________DOB: ____________S.S#: ____________
Employer Name: ______________________Phone #:______________________

**AUTO ACCIDENT INSURANCE COMPANY INFORMATION** / Date of Accident:____________
Name:______________________Phone #:______________________
Policy#:______________________Claim #:______________________
Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative ____________
Policy Holder: Name:______________________DOB: ____________S.S#: ____________

Please be advised that Texas Medical Institute does not accept Medicare or any of its subsidies. If you are a Medicare beneficiary, or become a beneficiary while receiving treatment at Texas Medical Institute, please notify our office immediately.

**IN CASE OF AN EMERGENCY**
Name: ______________________Phone#: ______________________
Address: ____________________________________________
Street Name & Number City State Zip

Patient's relationship to Policy Holder: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative ______________

TEXAS MEDICAL INSTITUTE

## MEDICAL HISTORY

**What treatment have you already received for your condition?**

□ Surgery: Was your surgery ____Successful ____Unsuccessful/who preformed this surgery? ________________________________
□ Physical Therapy: Was your therapy ____Successful ____Unsuccessful/ where was it? ____________________________________
□ Chiropractic Services: Was your treatment ____Successful ____Unsuccessful/ where was it_______________________________
□ Other ______________________________________________________________________ □ None
Name and address of the other Doctor(s) who treated you for your condition:_____________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Date of Last: Physical Exam________________ Spinal X-Ray ________________ Blood Test_________________
Spinal Exam _________________ Chest X-Ray ________________ Urine Test_________________
Dental X-Ray_________________ MRI, CT-Scan, Bone Scan_________ ________________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV | □ Yes □ No | Chicken Pox | □ Yes □ No | Liver Disease | □ Yes □ No | Rheumatoid Arthritis | □ Yes □ No |
| Alcoholism | □ Yes □ No | Diabetes | □ Yes □ No | Measles | □ Yes □ No | Rheumatic Fever | □ Yes □ No |
| Allergy Shots | □ Yes □ No | Emphysema | □ Yes □ No | Migraine Headaches | □ Yes □ No | Scarlet Fever | □ Yes □ No |
| Anemia | □ Yes □ No | Epilepsy | □ Yes □ No | Miscarriage | □ Yes □ No | Stroke | □ Yes □ No |
| Anorexia | □ Yes □ No | Fractures | □ Yes □ No | Mononucleosis | □ Yes □ No | Suicide Attempt | □ Yes □ No |
| Appendicitis | □ Yes □ No | Glaucoma | □ Yes □ No | Multiple Sclerosis | □ Yes □ No | Thyroid Problems | □ Yes □ No |
| Arthritis | □ Yes □ No | Goiter | □ Yes □ No | Mumps | □ Yes □ No | Tonsillitis | □ Yes □ No |
| Asthma | □ Yes □ No | Gonorrhea | □ Yes □ No | Osteoporosis | □ Yes □ No | Tuberculosis | □ Yes □ No |
| Bleeding Disorders | □ Yes □ No | Gout | □ Yes □ No | Pacemaker | □ Yes □ No | Tumors, Growths | □ Yes □ No |
| Breast Lump | □ Yes □ No | Heart Disease | □ Yes □ No | Parkinson's Disease | □ Yes □ No | Typhoid Fever | □ Yes □ No |
| Bronchitis | □ Yes □ No | Hepatitis | □ Yes □ No | Pinched Nerve | □ Yes □ No | Ulcers | □ Yes □ No |
| Bulimia | □ Yes □ No | Hernia | □ Yes □ No | Pneumonia | □ Yes □ No | Vaginal Infections | □ Yes □ No |
| Cancer | □ Yes □ No | Herniated Disk | □ Yes □ No | Polio | □ Yes □ No | Venereal Disease | □ Yes □ No |
| Cataracts | □ Yes □ No | Herpes | □ Yes □ No | Prostate Problem | □ Yes □ No | Whooping Cough | □ Yes □ No |
| Chemical Dependency | □ Yes □ No | High Cholesterol | □ Yes □ No | Prosthesis | □ Yes □ No | Other: ______________________ | |
| ______________________ | | Kidney Disease | □ Yes □ No | Have you ever had any nervous or mental illnesses? | □ Yes □ No | | |

Have you had psychiatric care? □ Yes □ No Have you received a medical discharge from the Armed Forces □ Yes □ No

| **EXERCISE** | **WORK ACTIVITY** | **HABITS** | |
|---|---|---|---|
| □ None | □ Sitting | □ Smoking | Packs/day__________________ |
| □ Moderate | □ Standing | □ Alcohol | Drinks/week________________ |
| □ Daily | □ Light Labor | □ Caffeine Drinks | Cups/Daily ________________ |
| □ Heavy | □ Heavy Labor | □ High Stress Level | Reason ___________________ |

**Women Only:** Are you pregnant? □Yes □No If yes Due Date: _________________ # of Pregnancies: _____________
Method of delivery: C-Section #______Vaginal #______Miscarriages #______Other Female Surgeries:_______________
_____________________________________________________________________________________________

**Injuries/Surgeries you have had** Descriptions Date
Falls ________________________________________________________________________________
Head Injuries ___________________________________________________________________________
Broken bones ___________________________________________________________________________
Dislocations ____________________________________________________________________________
Surgeries ______________________________________________________________________________

| **MEDICATIONS** | **ALLERGIES** | **VITAMINS/HERBS/MINERALS** |
|---|---|---|
| ________________________ | ________________________ | ____________________________ |
| ________________________ | ________________________ | ____________________________ |
| ________________________ | ________________________ | ____________________________ |

Pharmacy Name: _______________________________________ Phone #:_____________________

TEXAS MEDICAL INSTITUTE

# X-RAY Release Form

I have been advised by the doctor or staff member of this office that x-rays can be HAZARDOUS to an unborn child. At this time, and to the best of my knowledge, I am not pregnant. I consent to having life size, digital x-ray pictures taken.

Patient Signature:_______________________________________________

Date:_______________________________________________

Witness:_______________________________________________

Date:_______________________________________________

**FOR WOMEN ONLY**

# CONSENT TO TREATMENT

Date: ________________________

Patient Name: ____________________________________
(Print Name)

**Omit any statement, which you do not wish to authorize by marking a line through the statement with your initial and date.**

**Consent to Treatment:** I, as the patient or on behalf of the patient, do hereby consent to and authorize all medical, chiropractic and therapeutic treatment considered necessary or advised in the judgment of the physician on duty. I understand that no guarantees and/or assurances have been made as to the results which may be obtained.

**Financial Agreement**: I hereby guarantee payment for services at **Texas Medical Institute located at 6789 Camp Bowie; Fort Worth TX and/or 3304 S.W. Loop 820 Fort Worth TX and/or 8100 John Carpenter FWY. Dallas TX.** I understand that I will be held responsible for the court cost, legal fees, or agency fees which may be incurred in the collection of the account.

**Assignment of Benefits**: I hereby authorize all insurance companies to pay directly to **Texas Medical Institute** and any ancillary providers, any providers, any benefits and fees under my insurance policy or policies. I understand that this order does not relieve any of my obligations to pay the account or any balance that is not covered or paid by the insurance company carrier which may be my responsibility.

**Release of Medical Information:** I hereby consent and authorize **Texas Medical Institute's** Physicians and any ancillary providers, to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefit from my health insurance carrier.

**Teaching Facility:** I understand that **Texas Medical Institute** is affiliated with medical schools, nursing schools, and other academic programs and therefore resident physicians, interns, and students may be involved with my care.

**Nurse Practitioners/Physician Assistant:** I understand that **Texas Medical Institute** provides care by Physicians, Nurse Practitioners, and Physician Assistants. Nurse Practitioners and Physician Assistants are not physicians, but function under the supervision of a physician either directly or via protocols established by the physician.

I HAVE READ THE AUTHORIZATION, CONSENT, AND AGREEMENT AND I ACCEPT THE TERMS DESCRIBED ABOVE.

Patient Name: _________________________________ Date:_____________________________

Signature of Patient or Responsible Party ______________________________________

Relationship __________________________________________

Witness Signature ___________________________________________ Date _______________

# Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination test, diagnostic x-rays, and chiropractic modalities on myself (or on the patient names below for which I am legally responsible). All by which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back-up for the doctors of chiropractic named below.

**Names and Addresses of Offices and Clinics**

**Texas Medical Institute**
6789 Camp Bowie Blvd.
Fort Worth, TX 76116

**Texas Medical Institute**
3304 SE Loop 820
Fort Worth TX 76140

**Texas Medical Institute**
8100 John W. Carpenter Fwy Ste 100
Dallas, TX 75247

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE**

______________________________________________
Signature of Patient Date

______________________________________________
Printed Name of Patient

______________________________________________
Signature of Patient Representative (If minor or physically incapacitated)

______________________________________________
Witness Date

TEXAS MEDICAL INSTITUTE

## PATIENT COMFORT ASSESSMENT GUIDE

Name: ______________________________________________________________________________

Where is your pain: _______________________________________________________________

Circle the words that describe your pain;

| | | | | |
|---|---|---|---|---|
| aching | sharp | penetrating | throbbing | tender |
| nagging | shooting | burning | numb | stabbing |
| exhausting | miserable | gnawing | tiring | unbearable |

Circle ONE - occasional continuous

What time of day is your pain the worst? morning afternoon evening nighttime

Rate your pain by circling the number that best describes your pain at its **worst** in the last month.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

Rate your pain by circling the number that best describes your pain at its **least** in the last month.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

Rate your pain by circling the number that best describes your pain on average in the last month.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

Rate your pain by circling the number that best describes your pain right now.

1 2 3 4 5 6 7 8 9 10
(1 being the least 10 being the worst/extreme pain)

What makes you pain **better**?______________________________________________________________

What makes you pain **worse**?______________________________________________________________

What **treatments** or **medicines** are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) ____________________________________ No relief 1 2 3 4 5 6 7 8 9 10 Complete relief
Treatment or Medicine (include dose)

b) ____________________________________ No relief 1 2 3 4 5 6 7 8 9 10 Complete relief
Treatment or Medicine (include dose)

d) ____________________________________ No relief 1 2 3 4 5 6 7 8 9 10 Complete relief
Treatment or Medicine (include dose)

e) ____________________________________ No relief 1 2 3 4 5 6 7 8 9 10 Complete relief
Treatment or Medicine (include dose)

## PATIENT COMFORT ASSESSMENT GUIDE CONTINUED

What **side effect** or **symptoms** are you having? Circle the number that best describes your experience during the past week.

| | Symptom | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | Nausea | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| b. | Vomiting | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| c. | Constipation | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| d. | Lack of Appetite | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| e. | Tired | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| f. | Itching | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| g. | Nightmares | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| h. | Sweating | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| i. | Difficulty Thinking | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |
| j. | Insomnia | Barely Noticeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Sever Enough to Stop Medicine |

Circle the one number that describes how during the past week **pain has interfered** with your:

| | Area | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. | General Activity | Does not | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely |
| b. | Mood | Does not | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely |
| c. | Normal Work | Does not | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely |
| d. | Sleep | Does not | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely |
| e. | Enjoyment of Life | Does not | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely |
| f. | Ability to Concentrate | Does not | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely |
| g. | Relations with Other People | Does not | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Completely |

TEXAS MEDICAL INSTITUTE

# Patient Record of Disclosures

HIPPA Privacy rule: **III. Other Uses and Disclosures of Health Information** We will not use or disclose your health information for any purpose other than those identified in this written Authorization. We cannot take back any uses or disclosures already made with your permission.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone #: ________________________________
- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: ______________________________

☐ Work telephone #: ________________________________
- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: ______________________

☐ **Written Communication**
☐ Mail to my home address
☐ Mail to my work/office

☐ Other ____________________________
___________________________________

______________________________ ______________________ ______________________________
Patient Signature Date Print Name

Healthcare entities must keep records of PHI disclosures; information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosure for PHI may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

| Date | Disclosed to | Purpose | By Whom | 1 | 2 | 3 |
|---|---|---|---|---|---|---|
| | | | | | | |
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| | | | | | | |

1. Check this box if the disclosure is authorized
2. Print: T = Treatment Record; P = Payment Information; O = Other Healthcare provider
3. How was disclose made: F = Fax; P = Phone; E = E-mail; O = Other

## Standard Authorization Form
## To Use or Disclose Protected Health Information (PHI)

Patient Name:______________________________________ Date: _______________

Address: ____________________________________ SS#:xxx-xx- __ __ __ __

____________________________________ D.O.B: ______________

Receive Records From:

________________________________

________________________________

________________________________

________________________________

Release Records To:

Texas Medical Institute

6789 Camp Bowie Blvd

Fort Worth TX 76116

P: 817-731-2102 Fax: 817-731-2157

Please send a copy of my records as indicated for date(s) of Treatment: ____________________

Specifically:

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ MD Progress Notes
- ☐ Nursing Notes
- ☐ Social Serv. Notes
- ☐ Laboratory
- ☐ Radiology
- ☐ EEG/EKG/CAT Scan
- ☐ MD Orders
- ☐ other please specify:

____________________________

____________________________

Purpose for releasing medical information_____________________________________________

_______________________________________________________________________________

___________________________________ ___________________________________

**Signature of Patient, Parent or Legal Guardian** **Witness**

___________________________________

**Date**

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

___________________________________ ___________________________________

**Signature of Patient, Parent or Legal Guardian** **Witness**

___________________________________

**Date**

Patient Name:___________________________________

CURRENT CONDITONS:

CURRENT MEDICATIONS: