



You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Personal History

Today's Date: ____/____/____

Patient Name (print): _____ Age _____ Case Number _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell: _____ Work: _____
 Email: _____ Driver's License #: _____ SS#: _____
 D.O.B: ____/____/____ Referred By: _____
 Marital Status: _____ Spouse's Name: _____
 Emergency Contact: _____ Contact #: _____
 Relationship: _____
 Occupation: _____ Employer: _____
 Insurance Company: _____ Policy #: _____ Group #: _____

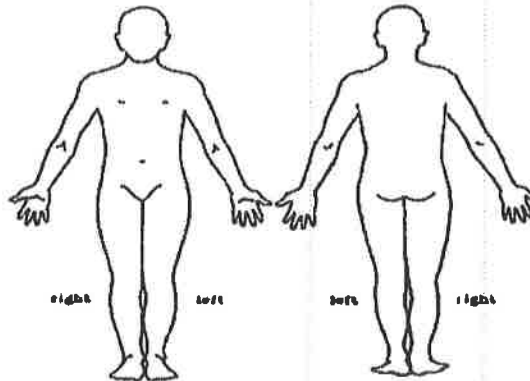
Personal Health History

Past Chiropractic Care? _____
 If Yes, When? _____ Where? _____

0 - NO PAIN
 10 - INTENSE PAIN

Example

	0	1	2	3	4	5	6	7	8	9	10
Neck											
1.											
2.											
3.											



Present Complaint: _____

Pain/Problem started on: _____ Pains are: Sharp Dull Constant Intermittent

1. What activities aggravate your condition/pain? _____
2. What activities lessen your condition/pain? _____
3. Is this condition/pain worse during certain times of the day? Morning Afternoon Evening
4. Is this condition/pain interfering with life? Work Sleep Routine Other _____
5. Is this condition getting progressively worse? If No, please check. If yes, please explain. _____
6. Have you seen anyone regarding this condition? If No, please check. If yes, please list. _____
7. Have you been under drug and medical care? If No, please check. If yes, please explain. _____
8. What medication(s) are you currently taking? If None, please check. _____
9. Have you had surgery? Yes No

10. What side effects have you experienced from surgery? If None, please check.

11. Is there a family history of?

Father's Side: Heart Disease Arthritis Cancer Diabetes Other: _____

Mother's Side: Heart Disease Arthritis Cancer Diabetes Other: _____

Symptoms

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fever | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of Balance |

1. Was Your Birth Traumatic?	Patient	Chiropractor's Comments
Long Delivery	Y	_____
Difficult Delivery	Y	_____
Forceps	Y	_____
Caesarian	Y	_____
Breach/Cephalic	Y	_____
Home Birth	Y	_____
Mother given drugs during delivery	Y	_____
Induced Labor	Y	_____

3. Growth and Development	Patient	Chiropractor's Comments
Fall out of Bed	Y	_____
Bang your head	Y	_____
Breastfed	Y	_____
Childhood Illness	Y	_____
Have any Accidents	Y	_____
Have Surgery	Y	_____
Take Drugs	Y	_____
Fall while learning to walk	Y	_____
Bullied by your siblings	Y	_____
Child Abuse	Y	_____
Chair pulled out while sitting	Y	_____
Fall down the stairs	Y	_____
Pulled by your arm	Y	_____
Experience other traumas	Y	_____

3. Current Health Habits	Patient	Chiropractor's Comments
Smoke	Y	_____
Drink	Y	_____
Diet (Do you eat healthy foods)	Y	_____
Have you been in accidents	Y	_____
Drugs (Prescribed or Non-Prescribed)	Y	_____
Have Teeth Problems	Y	_____
Have Eye Problems	Y	_____
Have Hearing Problems	Y	_____
Exercise Regularly	Y	_____
Have Sleeping Problems (Nightmares)	Y	_____
Have Occupational Stress	Y	_____
Have Physical Stress	Y	_____
Have Mental Stress	Y	_____
Have Hobbies/Sports Injuries	Y	_____
Sleeping Posture (Side/Stomach/Back)	Y	_____

4. Operations and Procedures	Date
Vaccinations	_____
Tonsillectomy	_____
Gall Bladder	_____
Back Operation	_____
Tubes in Ears	_____
Appendectomy	_____
Female Organs	_____
Rectal Surgery	_____
Sinus	_____
Hernia	_____
Thyroid	_____
Stomach	_____
Other:	_____

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of treatment plans Andrea Heikkinen would like for you to receive. Chiropractic Treatment Plans are designed to help get you feeling better quickly and to help you be as healthy as possible. Please review the explanations of the Chiropractic Treatment Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to:

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Signature of Patient and/or Legal Guardian

Date

Gonino Center for Healing
Gonino Wellness Chiropractic
6720 Horizon Road, Heath, TX 75032
Phone: 469-402-2800 Fax: 469-402-0348

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to dispense a separate draft to pay in full all services rendered payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the facility/physician named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case. A photocopy of this instrument will serve as the original.

Patient's Printed Name

Signature of Patient or Responsible Party

Signature of Witness

Date

Responsible Party Printed Name

Social Security Number

____/____/____
Date of Birth

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Informed Consent

We want your Chiropractic experience to be excellent. We are available to discuss with you the risks and benefits of the chiropractic adjustment and any treatments that we provide in our office. Our office offers treatments such as physical examinations, chiropractic adjustments by hand or with an instrument, myofascial release, energy balancing, electrical muscle stimulation, ultrasound, moist heat and ice pack treatment, lymphatic pump and Chi machine. These services and treatments can possibly create soreness, bruising and minor injuries in some patients. Our office will do our best to evaluate you for any risks you may have due to these treatments and will explain them individually. There are some risks to chiropractic adjustments such as bone fracture to weakened areas and bruising or strains to unhealthy muscles. There is a small percentage of the population that is at risk of stroke from chiropractic treatments. If Dr. Eddie Buhr, DC., finds that you are potentially at risk, she will offer you an alternative type of treatment. People of all ages can safely be adjusted with care and proper evaluation. I understand the risks that have been explained and consent to chiropractic examination and treatment under the direction of Eddie Buhr, DC.

Signature of Patient or Personal Representative

Patient's Printed Name

Date

Acknowledgement of receipt of Notice of Privacy Practices

By signing, I acknowledge that this office has provided a copy of the Notice of Privacy Practices and I have read it or it has been read to me. I understand that my patient records are confidential and will be respectively protected unless this office is given written permission from me to release specific information.

Signature of Patient or Personal Representative

Patient's Printed Name

Date

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Patient Communication

May we contact you or send detailed messages related to your treatment/appointments by:

Yes No Home Phone
Yes No Work Phone
Yes No Cell Phone
Yes No Mail
Yes No E-mail at Home E-mail Address _____
Yes No E-mail at Work E-mail Address _____

May we send postcard communications such as scheduling reminders, thank-you cards, sympathy cards, birthday cards, or holiday cards?

Yes No Home
Yes No Work

May we send you a periodic newsletter?

Yes No E-mail
Yes No Mail

May we discuss your treatment and/or appointment times with a spouse, parent or friend?
(Please List names below)

Signature of Patient or Personal Representative

Patient's Printed Name

Date