

**CONFIDENTIAL CHIROPRACTIC PATIENT CASE HISTORY**  
**DR. KAREN S. THOMASON, D.C.**

DATE \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ TDL# \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE# \_\_\_\_\_ CELL PHONE # \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_

MARITAL STATUS: M S W D      HOW MANY CHILDREN? \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

SPOUSE \_\_\_\_\_ EMPLOYER \_\_\_\_\_ PHONE# \_\_\_\_\_

NEAREST RELATIVE \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE# \_\_\_\_\_

PUPOSE OF THIS APPOINTMENT? \_\_\_\_\_

WHEN DID THIS PROBLEM BEGIN? \_\_\_\_\_ IS IT ACCIDENT RELATED? \_\_\_\_\_

IS THERE ANYTHING YOU CAN DO TO RELIEVE THE PROBLEM? YES \_\_\_ NO \_\_\_ IF YES PLEASE DESCRIBE \_\_\_\_\_

IF NO, WHAT HAVE YOU TRIED THAT HAS NOT HELPED? \_\_\_\_\_

WHAT MAKES PROBLEM WORSE?  
STANDING \_\_\_ SITTING \_\_\_ LYING \_\_\_ BENDING \_\_\_ LIFTING \_\_\_ TWISTING \_\_\_ OTHER \_\_\_\_\_

HAVE YOU EVER HAD ANY BROKEN BONES? YES \_\_\_ NO \_\_\_ IF YES DESCRIBE \_\_\_\_\_

HAS A PHYSICIAN TREATED YOU FOR ANY HEALTH CONDITION IN THE LAST YEAR? YES \_\_\_ NO \_\_\_ IF YES DESCRIBE \_\_\_\_\_

SERIOUS ILLNESSES (INCLUDE DATES) \_\_\_\_\_

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? \_\_\_\_\_

WHAT SURGERIES HAVE YOU HAD? (INCLUDE DATES) \_\_\_\_\_

WOMEN ONLY: ARE YOU PREGNANT OR IS THERE ANY POSSIBILITY YOU MAY BE? YES \_\_\_ NO \_\_\_ UNCERTAIN \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractic office. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will immediately be due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

PATIENT SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ACH Group, Inc. - Form PHQ-202

ACH Group Use Only rev 8/11/2002

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

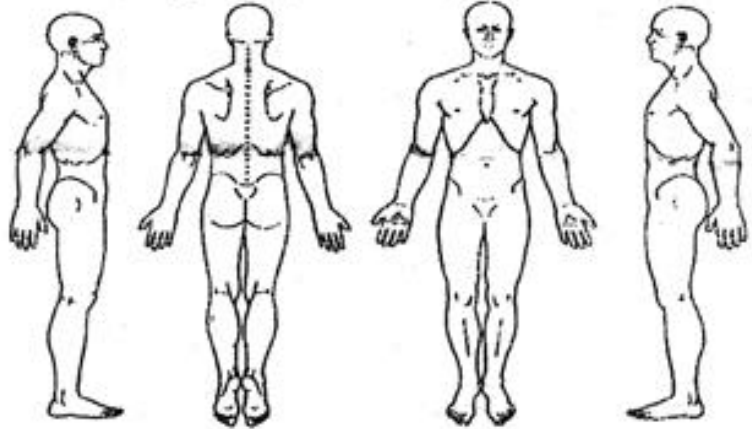
1. Describe your symptoms \_\_\_\_\_  
 \_\_\_\_\_

a. When did your symptoms start? \_\_\_\_\_

b. How did your symptoms begin? \_\_\_\_\_

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- Sharp       Shooting
- Dull ache     Burning
- Numb         Tingling

4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

- None Unbearable
- ①    ②    ③    ④    ⑤    ⑥    ⑦    ⑧    ⑨    ⑩

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all     ② A little bit     ③ Moderately     ④ Quite a bit     ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

- ① All of the time     ② Most of the time     ③ Some of the time     ④ A little of the time     ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent     ② Very Good     ③ Good     ④ Fair     ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One     ③ Medical Doctor     ⑤ Other  
 ② Other Chiropractor     ④ Physical Therapist

a. What treatment did you receive and when? \_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_     ③ CT Scan date: \_\_\_\_\_  
 ② MRI date: \_\_\_\_\_     ④ Other date: \_\_\_\_\_

9. Have you had similar symptoms in the past?

- ① Yes     ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office     ③ Medical Doctor     ⑤ Other  
 ② Other Chiropractor     ④ Physical Therapist

10. What is your occupation?

- ① Professional/Executive     ③ Laborer     ⑦ Retired  
 ② White Collar/Secretarial     ④ Homemaker     ⑧ Other  
 ⑥ Tradesperson     ⑤ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time     ③ Self-employed     ⑤ Off work  
 ② Part-time     ④ Unemployed     ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave those blank that do not apply.

CONDITION	Father AGE ( )	Mother AGE ( )	Spouse AGE ( )	Brothers AGE ( )	Sisters AGE ( )	Children AGE ( )
Arthritis						
Asthma/Allergies						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Neuritis						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						

List any of the above family members that are deceased, please list their age at death and cause: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient  
 Signature: \_\_\_\_\_

## Patient History Form

Patient \_\_\_\_\_ Date \_\_\_\_\_

Childhood Diseases: Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Others: \_\_\_\_\_

Unusual Childhood Diseases: \_\_\_\_\_

Adult Illnesses or Conditions: \_\_\_\_\_

Surgeries/Hospitalizations: \_\_\_\_\_

Fractures: \_\_\_\_\_

Medications \_\_\_\_\_

Are you allergic to any drugs or medications? \_\_\_\_\_

Last Physical (date) \_\_\_\_\_

Have you had or do you now have any of the following symptoms, which are or have been of significant distress to you? Please indicate with the letter N if you have these problems now or P if you have had these conditions previously.

N= Now

P=Previously

Headaches _____	Frequency _____	High Blood Pressure _____	Hands Cold _____
Neck Pain _____	_____	Difficulty Urinating _____	Arthritis _____
Stiff Neck _____	_____	Weakness in Extremities _____	Muscle Spasms _____
Sleeping Problems _____	_____	Breathing Problems _____	Frequent Colds _____
Back Pain _____	_____	Fatigue _____	Fever _____
Nervousness _____	_____	Light Bother Eyes _____	Sinus Problems _____
Tension _____	_____	Ears Ring _____	Diabetes _____
Irritability _____	_____	Loss of Balance _____	Indigestions Problems _____
Chest Pains/Tightness _____	_____	Fainting _____	Joint Pain/Swelling _____
Dizziness _____	_____	Loss of Smell _____	Menstrual Difficulties _____
Shoulder/Neck/Arm Pain _____	_____	Loss of Taste _____	Weight Loss/Gains _____
Numbness in Fingers _____	_____	Unusual Bowel Problems _____	Depression _____
Numbness in Toes _____	_____	Feet Cold _____	Loss of Memories _____
Buzzing in Ears _____	_____	Women: Are you Pregnant: _____	

Please indicate beside each activity whether you engage in it:

OFTEN = O      SOMETIMES= S      NEVER =N

Vigorous Exercise \_\_\_\_\_

Moderate Exercise \_\_\_\_\_

Alcohol Use \_\_\_\_\_

Drug Use \_\_\_\_\_

Tobacco Use \_\_\_\_\_

Caffeine \_\_\_\_\_

High Stress Activity \_\_\_\_\_

Other Specify: \_\_\_\_\_

## Patient Health Information Consent Form

We want you to know how your **Patient Health Information (PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their **PHI** for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested **PHI** to the Health Insurance Company (ies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all **PHI** to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their **PHI**. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Written Name of Patient

Date

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Signature of Patient

Date

# AUTHORIZATION FORM REGARDING THE USE & DISCLOSURE OF HEALTH INFORMATION

*I hereby authorize the following use or disclosure of my health information:*

**Entity of Person Authorized to Make the Use / Disclosure:** 1960 West Chiropractic

*In the event that 1960 West Chiropractic Center is entered in the space above, I understand that I may inspect or copy the health information to be used or disclosed. I further understand that the health information identified in the Authorization may be subject to re-disclosure by the recipient and therefore may no longer be protected by this rule. The following also need to be completed:*

*Will your practice be reimbursed, directly or indirectly, for the use/disclosure? Yes \_\_\_ No \_\_\_*

Entity or Person **To Whom** the Use / Disclosure Should Be Made: \_\_\_\_\_

Description of Information to Be Used / Disclosed: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Purpose of the Use / Disclosure: \_\_\_\_\_

Expiration Date / Expiration Event: \_\_\_\_\_

*I understand that I may refuse to sign this authorization and that treatment and payment cannot be conditioned upon my completion of this form. I understand that this authorization may be revoked in writing except to the extent that our practice has acted in reliance thereon.*

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If this authorization is being signed by a personal representative, describe the representative's authority to act for the individual:*

**PARTIAL ASSIGNMENT OF THE CAUSE OF ACTION,  
ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND TREATMENT AGREEMENT**

For the purposes of this Agreement, AOffice@ shall refer to: 1960 West Chiropractic Center.

I hereby direct any and all insurance carriers, health benefit plan administrators and sponsors, health maintenance organizations, preferred and independent provider organizations, attorneys, at-fault parties, tortfeasors, individuals, and any other entities, which may elect or be obligated to pay or disburse proceeds to me for any reason (APayers@), to pay directly to, and exclusively in the name of, **1960 West Chiropractic** in the amount of the full charges incurred by me at **1960 West Chiropractic** either now or in the future. Such charges shall include without limit the normal fees for **1960 West Chiropractic** services as described below, interest to the extent permitted by law, and any other charges incurred by me at **1960 West Chiropractic** ("my Charges"). For the purposes of this Agreement, AProceeds@ shall include the proceeds from any settlement, judgment, or verdict, as well as, without limit, the compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice.

I further grant a contractual lien to **1960 West Chiropractic** with respect to my Charges, however, I understand that nothing in this Agreement by itself shall be construed as an election by **1960 West Chiropractic** to claim protection under any statutory lien law.

I further assign to **1960 West Chiropractic**, insofar as permitted by law, all of my rights, remedies, and benefits to **1960 West Chiropractic**, as well as any and all causes of action that I might have against such Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in **1960 West Chiropractic** name, and the right to settle or otherwise resolve such causes of action as **1960 West Chiropractic** sees fit.

In the event that my treatment at **1960 West Chiropractic** relates to a personal injury, and I retain one or more attorneys to represent me regarding the personal injury matter, I direct each attorney to issue a letter of protection to **1960 West Chiropractic** regarding my Charges. Upon issuance, I agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of **1960 West Chiropractic**. I further direct (and **1960 West Chiropractic** hereby requests) each attorney to provide immediate notice to **1960 West Chiropractic** regarding any Proceeds received by the attorney relating to my personal injury, to promptly pay **1960 West Chiropractic** in full out of such Proceeds, and to provide a full accounting of such Proceeds to **1960 West Chiropractic**.

I authorize and direct **1960 West Chiropractic** to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one payer, I hereby authorize and direct **1960 West Chiropractic** to apply any Proceeds received from the Payer to any reductions, write-offs, or discounts, issued by another.

I authorize **1960 West Chiropractic** to endorse or sign my name on any and all checks listing me as a payee which are received by **1960 West Chiropractic** for payment of Charges incurred by me, my spouse or my dependents. I further authorize **1960 West Chiropractic** to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

In consideration for **1960 West Chiropractic** services, I agree to pay to **1960 West Chiropractic** its normal fees for such services. I understand, that at any time, I can request a copy of my total charges and that I remain personally responsible for them. Nothing in this Agreement requires **1960 West Chiropractic** to await payment for past Charges or for Charges as they accrue, and I agree to pay all accrued Charges in full upon demand. If **1960 West Chiropractic** must take action to collect from either me or any Payer, I will be responsible for the costs of such collection efforts including, without limit, court costs and attorney fees. I hereby waive any statute of limitations which may apply to the collection of my Charges.

This Agreement shall not be modified or revoked without the mutual written consent of **1960 West Chiropractic** and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of **1960 West Chiropractic** and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effort.

Patient Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Name of Custodial Parent or Legal Guardian (please print): \_\_\_\_\_

Parent/Guardian' Signature: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

HOW WERE YOU REFERRED TO US?

\*OUR PATIENT \_\_\_\_\_

\*DOCTOR \_\_\_\_\_

\*YELLOW PAGES \_\_\_\_\_

\*ATTORNEY \_\_\_\_\_

\*SIGN \_\_\_\_\_

\*HMO/PPO BOOK \_\_\_\_\_

\*INTERNET \_\_\_\_\_

\*OTHER \_\_\_\_\_

IN APPRECIATION FOR EVERY REFERRAL,  
YOU WILL RECEIVE  
A COMPLIMENTARY VISIT.

## ACCIDENTAL INJURY FORM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time: \_\_\_ am \_\_\_ pm Location of Accident \_\_\_\_\_

Dollar amount of damage sustained by your vehicle? \_\_\_\_\_

Make and model of your vehicle? \_\_\_\_\_

Make and model of responsible party's vehicle? \_\_\_\_\_

Was your car damage: ( ) minimal ( ) moderate ( ) severe

### AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

### ON-THE-JOB INJURY

How did the injury occur? \_\_\_\_\_

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

### OTHER

Describe the circumstances of the accident (Be Specific) \_\_\_\_\_

\*\*\*\*\*

### CHECK SYMPTOMS YOU HAVE NOTIED SINCE THE ACCIDENT

- |                                        |                                                 |                                             |                                       |
|----------------------------------------|-------------------------------------------------|---------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Neck Stiff   |
| <input type="checkbox"/> Feet Cold     | <input type="checkbox"/> Head Too Heavy         | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Nervousness  |
| <input type="checkbox"/> Hands Cold    | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ringing       | <input type="checkbox"/> Dizziness    |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Face Flushed       | <input type="checkbox"/> Back Pain    |
| <input type="checkbox"/> Constipation  | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Buzzing in Ears    | <input type="checkbox"/> Tension      |
| <input type="checkbox"/> Cold Sweats   | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Fever         | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Chest Pain   |
| <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Loss of Smell          | <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> Neck Pain    |
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Depression             |                                             |                                       |
| <input type="checkbox"/> Other         |                                                 |                                             |                                       |

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, \_\_\_\_\_ through \_\_\_\_\_

### INSURANCE INFORMATION

Your Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Name \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Ins. Co. \_\_\_\_\_ Address \_\_\_\_\_

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjuster \_\_\_\_\_ Company \_\_\_\_\_

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_

## CONSENT TO TREATMENT OF MINOR

**Karen S. Thomason, D.C.**

5020 FM 1960 W, B6  
HOUSTON, TEXAS 77069  
Telephone (713) 580-1961

I hereby request and authorize the above named doctor/clinic to perform diagnostic test and render chiropractic adjustments and other treatment to my \_\_\_\_\_ (indicate relationship to child)

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(Name of Child)

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient