BEECHER CHIROPRACTIC CLINIC

1001 PINELOCH, STE 700
HOUSTON, TX. 77062
PH: (281) 286-1300 FAX: (281) 286-1339

Confidential New Patient Information

The following information is needed for our files so we can better serve you as a patient. Please print and fill out all portions of this form. All information is confidential.

Patient Data:

Name: _____ Patient's Employer: _____

Address: _____ Business Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Cell: _____ WK Phone: _____ Occupation: _____

SSN: _____ SEX: __ M __ F Policy Holder's Employer (If different from above): _____

Birthdate: _____ Age: _____ # Of Children: _____ WK Phone: _____ Occupation: _____

Marital Status: __ Single __ Married __ Divorced __ Widowed Emergency Contact: _____

Referred By: _____ Relationship: _____ Phone: _____

Insurance Information: (Your Primary Medical Insurance)

Name of Insured: _____ Name of Insurance: _____

Relation to Patient: _____ Ins. Phone: _____

Birthdate: _____ SSN: _____ Group #: _____ Member #: _____

(Your Secondary Medical Insurance) If Any:

Name of Insurance: _____ Group #: _____ Member#: _____

Ins. Phone: _____

Health History

Present Complaint:

Briefly Describe Symptoms: _____

_____

List any/or all Doctors seen for this condition: _____

_____

MEDICAL HISTORY: If any of the following are relevant to your medical history, please check.

__ CANCER	__MUSCULAR DYSTROPHY	__POLIO	__ASTHMA	__ ARTHRITIS
__ EPILEPSY	__MULTIPLE SCLEROSIS	__DIABETES	__NEURITIS	__ SINUS TROUBLE
__ ANEMIA	__ CONVULSIONS	__NUMBNESS	__CONCUSSION	__ NERVOUSNESS
__ HEPATITIS	__HIGH BLOOD PRESSURE	__ DIZZINESS	__ HEART TROUBLE	

__OTHER IF OTHER, PLEASE LIST _____

Date of Last Physical Exam _____ Name of Doctor: _____

Describe and Date of any operations had: _____

Are you allergic to any medication: __NO __YES What Kind: _____

Are you taking any medication: __NO __YES What Kind: _____

Are you Pregnant: __NO __YES Date of last menstrual period: _____

PLEASE CONTINUE ON BACK OF THIS FORM

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AND INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THIS OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNTS AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT THIS OFFICE TO ENDORSE CO-ISSUED REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, THE UNDERSIGNED, A PATIENT IN THIS OFFICE HEREBY AUTHORIZE DR. WARD BEECHER (AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS) TO ADMINISTER SUCH TREATMENT AS IS NECESSARY, AND TO PERFORM THE FOLLOWING THERAPY AND MANIPULATION AND SUCH ADDITIONAL THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID TREATMENT. I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR CHIROPRACTIC TREATMENTS. THE REASONS WHY THE ABOVE NAMED TREATMENT IS CONSIDERED NECESSARY, ITS ADVANTAGES AND POSSIBLE COMPLICATIONS, IF ANY, AS WELL AS POSSIBLE ALTERNATIVE MODES OF TREATMENT, WHICH WERE EXPLAINED TO ME BY DR. BEECHER. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO THE RESULTS THAT MAY BE OBTAINED.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

CONSENT TO TREATMENT OF CHILD

I HEARBY AUTHORIZE DR. BEECHER AND ASSISTANTS TO ADMINISTER TREATMENT TO MY: SON OR DAUGHTER .

_____ _____

SIGNATURE OF LEGAL GUARDIAN DATE

ASSIGNMENT OF RIGHTS

YOUR INSURANCE COMPANY IS INSTRUCTED TO PAY BEECHER CHIROPRACTIC CLINIC FOR ALL PROFESSIONAL SERVICES RENDERED AT THIS OFFICE. THIS INSTRUCTION TO MY INSURANCE COMPANY IS MY ASSIGNMENT OF RIGHTS UNDER MEDICAL COVERAGE TO THE EXTENT OF MY BILL. THIS INCLUDES ALL CLAIMS, BE THEY 1ST OR 3RD PARTY CLAIMS. ANY SUM OF MONEY PAID UNDER ASSIGNMENT SHALL BE CREDITED TO MY ACCOUNT AND I SHALL PERSONALLY BE LIABLE FOR ANY UNPAID BALANCES DUE TO THE DOCTOR (UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE AT TIME OF SERVICE. ALSO, I AM PERSONALLY LIABLE FOR ANY UNPAID ACCOUNTS FOR HOSPITAL, DIAGNOSTIC AND CONSULTANT SERVICES. IT IS ALSO MY UNDERSTANDING THAT MY INSURANCE COMPANY AT DATE OF SERVICE MAYBE SENDING PAYMENTS TO ME FOR SERVICES RENDERED AT BEECHER CHIROPRACTIC CLINIC. UPON THE RECEIPT OF THESE CHECKS AND REMITTANCES, I AGREE TO BRING THESE ITEMS INTO BEECHER CHIROPRACTIC CLINIC.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

HIPPA COMPLIANCE/PRIVATE PRACTICE LAWS

BY SIGNING I HEREBY STATE THAT I AM AWARE OF THE PRACTICE PRIVACY NOTICE AND THAT THE PRIVACY NOTICE IS LOCATED AT MY DISPOSAL IN THE OFFICE AND I CAN REQUEST IT FOR REVIEW AT ANY TIME. I HEREBY AGREE TO ALL GUIDELINES AS IS NECESSARY FOR THE PRACTICE TO CONDUCT ITS HEALTH CARE OPERATIONS.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PLEASE COMPLETE THE QUESTIONAIRE ON THE FOLLOWING PAGE.

HEALTH STATUS QUESTIONAIRE (HSQ-12)

Name: _____ Date: _____ Date of Injury: _____

Please circle the number which best describes your health from time of injury or when pain began, unless otherwise specified:

1. In general, would you say your health is:

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

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A lot	Yes, Limited A little	No, Not Limited At All
2. Lifting or carrying groceries.....	1	2	3
3. Climbing several flights of stairs.....	1	2	3
4. Walking several blocks.....	1	2	3

5. Since the time of injury or when your pain began, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health?

None at all... 1
A little bit.....2
Moderately 3
Quite a bit... 4
Couldn't do any work 5

6. During the past 4 weeks, or when your pain began or injury occurred, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems (such as feeling depressed or anxious)?

None at all.....1
A little bit.....2
Moderately.....3
Quite a bit.....4
Extremely.....5

7. During the past 4 weeks, or when your pain began or injury occurred, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

None.....1
Very Mild.....2
Mild.....3
Moderate.....4
Severe.....5

8. How much bodily pain have you had since the time of injury or when your pain began?

None.....1
Very Mild.....2
Mild.....3
Moderate.....4
Severe.....5
Very Severe.....6

These questions are about how you feel and how things have been with you during the past 4 weeks or from the start of your pain or injury. For each question, please give the one answer that comes closest to the way you have been feeling.

PLEASE CONTINUE ON FOLLOWING PAGE.

HEALTH STATUS QUESTIONAIRE, PAGE 2

How much of the time during the past 4 weeks…

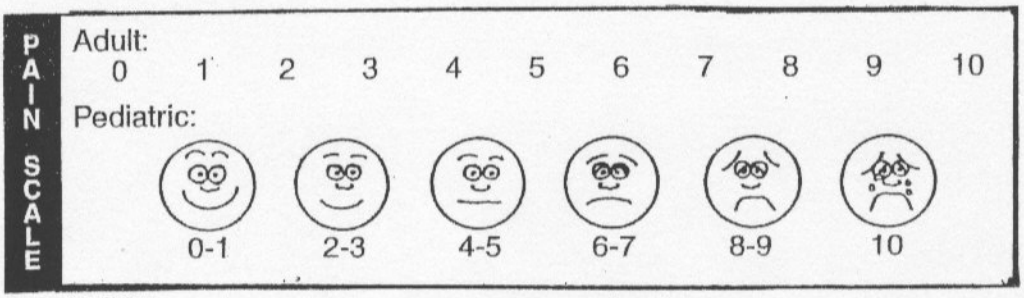
	All of the Time	Most of the time	A Good bit of the time	Some of the time	Little of the time	None of the time
9. Have you felt peaceful & calm?	1	2	3	4	5	6
10. Did you have a lot of energy?	1	2	3	4	5	6
11. Have you felt downhearted or blue?	1	2	3	4	5	6
12. Have you been a happy person?	1	2	3	4	5	6

Please answer YES or NO for each question by circling 1 or 2 on each line.

	Yes	No
13. In the past year, have you had 2 weeks or more during which you felt sad blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	1	2
14. Have you had 2 yrs or more in your life when you felt depressed or sad most of days, even if you felt okay sometimes?	1	2
15. Have you felt depressed or sad much of the time in the past year?	1	2

PLEASE MARK AN "X" IN THE BOX THAT BEST DESCRIBES YOUR LEVEL OF PAIN FOR THE TIME SPECIFIED.

	No Pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable
A. Right Now:													
B. Average Pain:													
C. At Best:													
D. At Worst:													



PAIN DRAWING

Please be sure to mark the area on your body where you feel the described sensation, using the appropriate markings. You may use all the areas on the body including the face and feet.

Numbness ------ **Pins & Needles** 0000 **Burning Pain** XXXX **Stabbing Pain** ////// **Aching Pain** ((((((