ELLIS
CHIROPRACTIC

1302 South Medford Drive • Lufkin, Texas 75901
936.639.1488 phone • 936.639.5064 fax

PATIENT CASE HISTORY

Name _____ Date _____

Address _____ City/Zip _____

Home Ph _____ Work _____ Cell _____

SSN _____ DOB _____ Email _____

Employer _____ Work Status: Full-Time Part-Time Not Employed Retired

Marital Status: S M D W Who Referred You _____

Student: ( ) Yes ( ) No If YES, Full Time Part Time What School _____

Insurance: _____ Relationship to Insured: Myself Spouse Other _____

If the insurance is in the name of your spouse or parent, please answer the following:

Name of Spouse / Parent _____ Spouse / Parent Date of Birth _____

SSN of Spouse / Parent _____ Spouse / Parent Phone #_____

Chief Complaint / List Current Problems

1. _____ Duration-(How Long) _____ Previous Episodes ___
2. _____ Duration-(How Long) _____ Previous Episodes ___
3. _____ Duration-(How Long) _____ Previous Episodes ___

Are your present problems due to an injury? ( ) No ( ) Yes Date of Injury _____

Please Mark the intensity of your pain today

1 – NO PAIN
10 – MOST INTENSE PAIN EVER FELT

Example _____ Neck
1 2 3 4 5 6 7 8 9 10

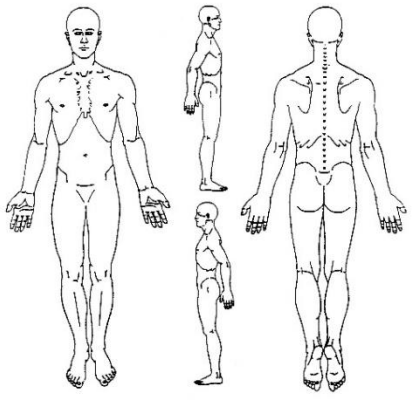
1. _____
1 2 3 4 5 6 7 8 9 10

2. _____
1 2 3 4 5 6 7 8 9 10

3. _____
1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below

N – Numbness P – Pain T – Tingling
A – Ache S – Soreness ST - Stiffness



HABITS

- ☐ Smoking Packs Per Day _____
- ☐ Drinking Alcohol Per Day _____
- ☐ Coffee Cups Per Day _____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily _____ Type

FAMILY HISTORY

	Diabetes	Heart	Stroke	Cancer	Back
Mother					
Father					
Brother					
Sister					

Please check if you have ever had any of the associated symptoms:

GENERAL SYMPTOMS
- ☐ Allergies
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Loss of Weight
- ☐ Numbness arms/legs

CARDIO-VASCULAR
- ☐ High Blood Pressure
- ☐ Previous Heart Trouble
- ☐ Stroke
- ☐ Swelling Ankles

MUSCLES & JOINTS
- ☐ Arthritis
- ☐ Foot Trouble
- ☐ Hernia
- ☐ Stiff Neck
- ☐ Swollen Joints
- ☐ Tremors/Twitching
- ☐ Weakness

EYE/EAR/NOSE/THROAT
- ☐ _____

RESPIRATORY
- ☐ _____

FOR WOMEN ONLY
- ☐ Miscarriage
- ☐ Pregnant at this time

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Inability to Control Urine
- ☐ Prostate Trouble

SKIN OR ALLERGIES
- ☐ _____

GASTRO-INTESTINAL
- ☐ _____

OPERATIONS AND PROCEDURES

DATE		DETAILS
_____	Back Operation	_____
_____	Hernia	_____
_____	Female Organs	_____
_____	Other	_____

☐ I have never had any operations / surgeries.

List any accidents or falls and dates: ☐ Car _____ ☐ Recreational Vehicle _____

☐ Sports _____ ☐ School _____ ☐ Other _____

Have you ever had a spinal tap(s) or spinal injection(s)? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ No ☐ Yes When? _____ By whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication(s) – prescription or over the counter? ☐ No ☐ Yes What drugs? _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare the necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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, all fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate using Chiropractic Health Care, and I give authority for these procedures to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition(s) nor for any medical diagnosis.

Patient/s/Guardian's Signature X _____ Date _____

PATIENT HISTORY

Name: _____ Date: _____

Please answer all questions thoroughly

Completion of this form helps the doctor determine what's wrong with you.
He will not see you without this form being filled out completely.

1. Please describe the location of your pain. Where does it start? _____

_____

2. Are your symptoms constant or do they come and go? _____

3. Did your symptoms appear gradually or suddenly? _____

4. When did your symptoms first appear? _____

5. What makes your symptoms worse (bending, sitting, riding, etc.)? _____

_____

6. What makes your symptoms better (heat, cold, medication, rest)? _____

_____

7. Please describe the symptoms (sharp, dull, ache, burning, shooting, throbbing, etc.) _____

_____

8. Is pain worse in the morning, afternoon, evening, night or none. _____

9. Does it radiate (arm, fingers, leg, toes, back)? _____

10. What might you have done to cause your symptoms? _____

_____

11. Have you ever had a similar episode in the past? _____

12. Have you seen another Doctor for this condition? If so, who? _____

13. What was his/her diagnosis? _____

14. What treatment did he/she prescribe? _____

15. Please describe what you do in your job or occupation. _____

16. For Women: Are you pregnant (or possibly could be)? _____

NOTES: _____

_____

_____

_____

_____

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RECORDS TRANSFER REQUEST

Date: _____

To: _____
(Doctor / Hospital)

I hereby authorize the release of my x-rays and records or copies of such and request that they be transferred to:

Dr. Keven M. Ellis, D.C.
Ellis Chiropractic
1302 S. Medford Drive
Lufkin, Texas 75901
Ph: 936-639-1488, Fax: 936-639-5064
Email: records@ellischiropractic.com

_____ _____
Print Patient's Name **Signature (patient, parent or guardian)**

NOTICE OF PRIVACY PRACTICES

Keven M. Ellis, D.C.
Ellis Chiropractic | East Texas Drug Testing
1302 South Medford Drive • Lufkin, Texas 75901
936.639.1488 Ellis Chiropractic (P) • 936.639.1502 ETDT (P) • 936.639.5064 (F)

THIS NOTICIE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GETACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on_____(insert today's date) and remains until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available uponrequest.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the top of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. We may also share drug, alcohol, or paternity testing results and/or DOT medical examination information with your current or potential employer, the Judge, attorney(s) involved in your case and/or specific caseworkers pertaining to your case, unless you specify otherwise.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer.The information on or accompanying the bill may include your medical information. By signing this, I agree to the charges. All services are non-refundable.

ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices, and I have been provided with an opportunity to review it.

Name_____ Birthdate _____

Signature_____ Date _____