HEALTH PLUS Chiropractic & Acupuncture

14901 State Highway 249, Suite 108, Houston, Texas 77086
Phone: (832) 534-4195 Fax: (832) 534-4159
Email: Info@HealthPlusChiro.com www.HealthPlusChiro.com

PATIENT HEALTH INFORMATION

ABOUT YOU

Patient File Number: _____

Title: ☐Mr. ☐Mrs. ☐Ms. Date of Birth: _____ Age: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ Phone Number: _____

How did you find us? ☐Internet ☐Walk-in ☐Health Insurance ☐Doctor _____ ☐Other people _____

Have you been to a Chiropractic Clinic before? ☐No ☐Yes. When? Whom? _____

Other treating Doctor for this condition? ☐*NONE* ☐Yes. Whom? _____

Treatment(s) received for this condition? ☐*NONE* ☐Medications ☐Physical therapy ☐Other _____

SOCIAL HISTORY *(Please fill out completely, including your occupation/job, exercise, and activities/hobbies)*

Marital Status ☐Single ☐Married ☐Widowed ☐Divorced _____ Occupation / Job: _____

Children? ☐No ☐Yes _____ Tobacco? ☐No ☐Yes _____ Alcohol? ☐No ☐Yes _____ Drugs? ☐No ☐Yes _____

Exercises? ☐No ☐Yes, ☐Cardio (walk / run / jog) ☐Weight lifting ☐Sports ☐Other _____

Daily Activities / Hobbies: _____

I want to ☐Reduce pain ☐Fix the problem ☐Return to work, daily activities & exercises ☐Other _____

PAST MEDICAL HISTORY *(Please list all information – Select **None** if applicable – Indicate approximate year or time frame)*

Surgery: _____ ☐*None*

Injury: _____ ☐*None*

Medication: _____ ☐*None*

Treatment: _____ ☐*None*

Allergy: _____ ☐*None*

FAMILY HISTORY *(Please list any condition(s) that your family members have – Select **None** if applicable)*

Mother: ☐*NONE* ☐Scoliosis ☐Arthritis ☐Cancer ☐Diabetes ☐Multiple Sclerosis ☐Heart disease ☐Other _____

Father: ☐*NONE* ☐Scoliosis ☐Arthritis ☐Cancer ☐Diabetes ☐Multiple Sclerosis ☐Heart disease ☐Other _____

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REVIEW OF SYSTEMS

Constitutional	☐Cancer ☐AIDS / HIV+ ☐Night sweats ☐Unexplained weight loss / gain ☐Fever ☐Chills ☐Loss of appetite ☐Frequent lack of energy (Fatigue) ☐***None of the above***
Musculoskeletal	☐Broken bones ☐Rheumatoid Arthritis ☐Osteoarthritis ☐Scoliosis ☐Osteoporosis ☐Osteopenia ☐Gout ☐Metal Implants ☐Spinal surgery ☐***None of the above***
Neurological	☐Strokes / TIA ☐Seizures ☐Multiple Sclerosis ☐Tremors ☐Loss of balance ☐Loss of consciousness ☐Arms / Legs Weakness ☐Dizziness ☐Memory loss ☐Numbness ☐Vertigo ☐Decreased sensation ☐Facial weakness ☐Headache ☐Sleep disturbance ☐***None of the above***
Cardiovascular	☐High cholesterol ☐High blood pressure ☐Low blood pressure ☐Chest pain (Angina) ☐Heart attacks ☐Heart disease ☐Irregular heart beat ☐Swelling of legs ☐Varicose veins ☐Pacemaker ☐Difficult breathing lying down ☐Shortness of breath with exertion / exercise ☐***None of the above***
Respiratory	☐Shortness of breath ☐Asthma ☐Wheezing ☐Frequent cough ☐Coughing blood ☐Difficulty breathing ☐COPD ☐Emphysema ☐Sputum ☐***None of the above***
Gastrointestinal	☐Abdominal pain ☐Nausea / Vomiting ☐Vomiting of blood ☐Black or bloody stools ☐Jaundice ☐Loss of bowel control ☐***None of the above***
Genitourinary	☐Painful urination ☐Frequent urination ☐Can't control (Incontinence) urination ☐Blood in urine ☐Dialysis ☐Kidney disease ☐Sexually Transmitted Infection (Disease) ☐Hernia *Females*: ☐*Pregnancy* ☐Irregular menstruation ☐Vaginal discharge ☐***None of the above*** *Males*: ☐Erectile dysfunction ☐Prostate problem ☐Testicular pain ☐***None of the above***
Endocrine	☐Diabetes ☐Thyroid condition (Hypo | Hyper) ☐Cold or Heat intolerance ☐Goiter ☐Excessive sweating ☐Excessive appetite ☐Excessive thirst ☐Hair loss ☐***None of the above***
HEENT	☐Dizziness ☐Double vision ☐Blurred vision ☐Ear drainage ☐Ear ringing (Tinnitus) ☐Sore throat ☐Pain with swallowing ☐Frequent Nose bleeds (Epistaxis) ☐***None of the above***
Integumentary	☐Skin rashes ☐Skin color changes ☐Skin lesions / Ulcers ☐Psoriasis ☐Eczema ☐Nail color changes *Breast*: ☐Breast pain ☐Breast lumps ☐Breast discharge ☐***None of the above***
Psychiatric	☐Anxiety ☐Confusion ☐Depression ☐Suicidal thought ☐Bipolar ☐Loss or change in appetite ☐Insomnia ☐Psychiatric diagnosis ☐Psychiatric medications ☐***None of the above***
Others (not listed)	_____

I have read the above information, certify it to be true and correct to the best of my knowledge. I hereby authorize Health Plus Chiropractic & Acupuncture to provide me with examinations, chiropractic care, acupuncture therapy, and treatments, in accordance with this state's statutes.

Patient Name	**Name of Custodial Parent / Legal Guardian**
Patient Signature	**Parent / Guardian Signature**
Date	**Date**

******Office Use Only******

Signature: _____ Nhat Vu, D.C. **Date:** _____

HEALTH PLUS Chiropractic & Acupuncture

INFORMED CONSENT

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We (Health Plus Chiropractic & Acupuncture) may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and / or temporary increase in symptoms, lack of improvement of symptoms, burns and / or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. Associated risk factors for acupuncture include but are not limited to the following: bruising, blistering, bleeding, redness around the site where the needle was inserted, weakness, fainting, nausea, or temporary discoloration of the skin, possible aggravation of the symptoms existing prior to treatment, skin infection or broken needle. The Doctor (Health Plus Chiropractic & Acupuncture) will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities, e.g. sneezing, driving, & playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events / per one million persons / year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

Open Room Authorization: I hereby request and authorize the Doctor(s) and Staffs of Health Plus Chiropractic & Acupuncture perform therapy modalities, rehabilitation & treatments for me or the patient above in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my conversations during the course of my care. Should I need to speak with a doctor at any time in private, the doctor or staffs will provide a room for these conversations.

Consent for Minor (younger than 18-year-old)

I, the undersigned **custodial parent or legal guardian** of the patient identified below (minor child), hereby request and authorize the Doctor(s) of Health Plus Chiropractic & Acupuncture to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor child. This authorization also extends to all other Doctors and office Staff members and is intended to include acupuncture treatment at the doctor's discretion.

I have read, or have had read to me, the above consent and authorization. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive treatments as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from the doctor in this office for my present condition and for any future condition(s) for which I seek care from this office.

Patient Name	**Name of Custodial Parent / Legal Guardian**
Patient Signature	**Parent / Guardian Signature**
Date	**Date**

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a HIPAA *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to a copy and inspection of the HIPAA *Notice of Privacy Practices* prior to signing this authorization form.
- The right to have my medical information amended.
- The right to request to receive confidential communication by alternative means or at alternative location.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
- The right to revoke this authorization, at any time, in writing, except to the extent that your doctor or the doctor's practice has taken action in reliance on the use or disclosure indicated in authorization.

_____	_____
Patient Name	**Name of Custodial Parent / Legal Guardian**
_____	_____
Patient Signature	**Parent / Guardian Signature**
_____	_____
Date	**Date**

Health Plus Chiropractic & Acupuncture

Doctor/Staff: ☐Nhat Vu, D.C. ☐_____ ******Office Use Only******

Signature: _____ **Date:** _____

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YOUR MEDICAL SYMPTOMS

It is very important for us to have a thorough history of your conditions. As each symptom could be unrelated from another, thus they require different type of treatment. Please take a moment and fill out the details for each complaint separately. Additional pages will be provided if needed.

NECK SYMPTOM (Pain, discomfort, stiffness, numbness, etc.) ☐Left ☐Right ☐*No complaint of neck*

My pain level (most of the time) ☐No Pain —0 ☐Mild —1—2—3 ☐Moderate —4—5—6 ☐Severe —7—8—9 ☐Extreme —10

How often? (percentage) 0—5—10—15—20—25—30—35—40—45—50—55—60—65—70—75—80—85—90—95—100 % of awake time

It started ☐Suddenly ☐Gradually Date? _____ My symptom is ☐Getting better ☐Unchanged ☐Worsen

How it happened? ☐Motor vehicle collision (MVC) ☐Work Injury ☐Sports Injury ☐Injury ☐Other _____

_____

MVC only Have you had this symptom before motor vehicle collision? ☐No ☐Yes, When? Severity? _____

Quality ☐Achy ☐Dull ☐Deep ☐Sharp ☐Burning ☐Stabbing ☐Throbbing ☐Numbness ☐Cramping ☐Other _____

Feels *Better* with ☐*NONE* ☐Medication ☐Rest ☐Ice ☐Heat ☐Stretching ☐Other _____

Feels *Worse* with ☐Turning of neck Lt Rt ☐Hold head still ☐Looking up / down ☐Movement ☐Other _____

Neck pain radiates to ☐*NONE* ☐Head ☐Shoulder Lt Rt ☐Arm Lt Rt ☐Hand Lt Rt ☐Other _____

Neck symptom worsens in ☐Morning ☐Afternoon ☐Evening ☐Bed time ☐Unaffected by time of day

BACK SYMPTOM (Pain, discomfort, stiffness, numbness etc.) ☐Left ☐Right ☐*No complaint of back*

My pain level (most of the time) ☐No Pain —0 ☐Mild —1—2—3 ☐Moderate —4—5—6 ☐Severe —7—8—9 ☐Extreme —10

How often? (percentage) 0—5—10—15—20—25—30—35—40—45—50—55—60—65—70—75—80—85—90—95—100 % of awake time

It started ☐Suddenly ☐Gradually Date? _____ My symptom is ☐Getting better ☐Unchanged ☐Worsen

How it happened? ☐Motor vehicle collision (MVC) ☐Work Injury ☐Sports Injury ☐Injury ☐Other _____

_____

MVC only Have you had this symptom before motor vehicle collision? ☐No ☐Yes, When? Severity? _____

Quality ☐Achy ☐Dull ☐Deep ☐Sharp ☐Burning ☐Stabbing ☐Throbbing ☐Numbness ☐Cramping ☐Other _____

Feels *Better* with ☐*NONE* ☐Medication ☐Rest ☐Ice ☐Heat ☐Stretching ☐Other _____

Feels *Worse* with ☐Sitting ☐Standing ☐Walking ☐Lifting ☐Getting Up ☐Lying down ☐Bending ☐Other _____

Back pain radiates to ☐*NONE* ☐Buttock Lt Rt ☐Hip Lt Rt ☐Leg Lt Rt ☐Foot Lt Rt ☐Other _____

Back symptom worsens in ☐Morning ☐Afternoon ☐Evening ☐Bed time ☐Unaffected by time of day

Patient Name: _____ **Date:** _____

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HEADACHE ☐Back of head ☐Front of head ☐Side of head Left Right ☐*No complaint of headache*

My pain level (most of the time) ☐No Pain —0 ☐Mild —1—2—3 ☐Moderate —4—5—6 ☐Severe —7—8—9 ☐Extreme —10

How often? (percentage) 0—5—10—15—20—25—30—35—40—45—50—55—60—65—70—75—80—85—90—95—100 % of awake time

It started ☐Suddenly ☐Gradually Date? _____ My symptom is ☐Getting better ☐Unchanged ☐Worsen

How it happened? ☐Motor vehicle collision (MVC) ☐Work Injury ☐Sports Injury ☐Injury ☐Other _____

_____

MVC only Have you had this symptom before motor vehicle collision? ☐No ☐Yes, When? Severity? _____

Quality ☐Dull ☐Deep ☐Sharp ☐Stabbing ☐Throbbing ☐Other _____

Feels *Better* with ☐*NONE* ☐Medication ☐Rest ☐Ice ☐Heat ☐Other _____

Feels *Worse* with ☐Neck/Head movement ☐Watching TV/Computer use ☐Other _____

Other Areas (e.g. Chest, Shoulder, Hip, Knee, etc.) _____ ☐N/A

My pain level (most of the time) ☐No Pain —0 ☐Mild —1—2—3 ☐Moderate —4—5—6 ☐Severe —7—8—9 ☐Extreme —10

How often? (percentage) 0—5—10—15—20—25—30—35—40—45—50—55—60—65—70—75—80—85—90—95—100 % of awake time

It started ☐Suddenly ☐Gradually Date? _____ My symptom is ☐Getting better ☐Unchanged ☐Worsen

How it happened? ☐Motor vehicle collision (MVC) ☐Work Injury ☐Sports Injury ☐Injury ☐Other _____

_____

MVC only Have you had this symptom before motor vehicle collision? ☐No ☐Yes, When? Severity? _____

Quality ☐Dull ☐Deep ☐Sharp ☐Stabbing ☐Throbbing ☐Other _____

Feels *Better* with ☐*NONE* ☐Medication ☐Rest ☐Ice ☐Heat ☐Other _____

Feels *Worse* with ☐Movement ☐Other _____

Other Areas (e.g. Chest, Shoulder, Hip, Knee, etc.) _____ ☐N/A

My pain level (most of the time) ☐No Pain —0 ☐Mild —1—2—3 ☐Moderate —4—5—6 ☐Severe —7—8—9 ☐Extreme —10

How often? (percentage) 0—5—10—15—20—25—30—35—40—45—50—55—60—65—70—75—80—85—90—95—100 % of awake time

It started ☐Suddenly ☐Gradually Date? _____ My symptom is ☐Getting better ☐Unchanged ☐Worsen

How it happened? ☐Motor vehicle collision (MVC) ☐Work Injury ☐Sports Injury ☐Injury ☐Other _____

_____

MVC only Have you had this symptom before motor vehicle collision? ☐No ☐Yes, When? Severity? _____

Quality ☐Dull ☐Deep ☐Sharp ☐Stabbing ☐Throbbing ☐Other _____

Feels *Better* with ☐*NONE* ☐Medication ☐Rest ☐Ice ☐Heat ☐Other _____

Feels *Worse* with ☐Movement ☐Other _____

Patient Name: _____ **Date:** _____

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AUTOMOBILE COLLISION & INJURY INFORMATION

Your Information

Patient Name: _____ DOB: _____

Date of Injury: _____ Estimated Time: _____ AM PM

I was the ☐Driver ☐Front Passenger ☐Rear Passenger (Left / Middle / Right) # of people in my vehicle _____

My vehicle _____ (Make / Model) _____ (Year)

Other vehicle _____ (Make / Model) _____ (Year)

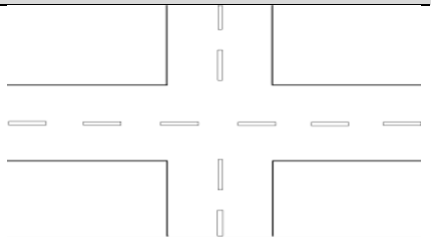
Describe and / or Draw the auto collision

_____

_____

_____

_____



Collision Description *(Select all that apply to you)*

Impact ☐Rear impact ☐Front impact ☐Left Side (Driver's Side) impact ☐Right Side impact

At the time of impact, ***My vehicle*** was ☐Stopped ☐Slowing down ☐Traveling **Estimated Speed**: *slow – moderate – fast*

At the time of impact, ***Other vehicle*** was ☐Stopped ☐Slowing down ☐Traveling **Estimated Speed**: *slow – moderate – fast*

During and after collision, my vehicle *(Select all that apply)*

☐Kept going straight, not hitting anything
☐Spun around, not hitting anything
☐Was hit by another vehicle
☐Kept going straight, hitting another car in front
☐Spun around, hitting another car
☐Spun around, hitting object other than car

Describe yourself during the collision *(Select all that apply)*

☐Wearing Seatbelt with Lap and Shoulder Strap
☐Aware of the impending collision and braced myself
☐Head and torso were facing straight
☐Hand(s) were on the steering wheel ☐Left ☐Right ☐N/A
☐Unaware of impending collision
☐Aware of the impending collision and relaxed before collision
☐Head and torso were turned to the side ☐Left ☐Right
☐Left ☐Right foot was on the ☐Gas pedal ☐Brake ☐N/A

Areas of your vehicle that were damaged *(Select all that apply)*

☐Windshield ☐Seat bent or damaged ☐Dashboard ☐Steering wheel
☐Side or rear window broken ☐Front / Rear Bumper ☐Other _____

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Indicate if your body hit something or was hit by anything

Head	☐Steering wheel ☐Airbag ☐Headrest ☐Roof ☐Other _____	☐*Don't remember*
Chest	☐Seatbelt ☐Airbag ☐Other _____	☐*Don't remember*
Shoulder	☐Seatbelt ☐Side door ☐Side window ☐Other _____	☐*Don't remember*
Knee	☐Dashboard ☐Other _____	☐*Don't remember*
Arm	☐Steering wheel ☐Dashboard ☐Other _____	☐*Don't remember*
Leg	☐Dashboard ☐Other _____	☐*Don't remember*
Other	_____	

Headrest / Head Restraints

☐Movable, head restraints ☐Fixed, non-movable head restraints ☐No head restraints

My Headrest / Head restraints is

☐At the top of the back of the head ☐Midway height of the back of the head

☐Lower height of the back of the head ☐Located at the level of neck or shoulder

YES	NO	
☐	☐	Did you lose consciousness or black out for any time after the collision? How long? _____
☐	☐	Did you go to the Emergency Room or Hospital? If Yes, Where? _____
		When? ☐Same Day ☐Other _____ By? ☐Ambulance ☐Myself ☐Other People _____
☐	☐	Did you go to any other Doctor and/or Clinic before coming here? If Yes, Where? _____
☐	☐	Were you prescribed medications? ☐Pain ☐Muscle relaxants? Name? _____
☐	☐	Did you take any diagnostic images? ☐X-rays ☐CT-Scan ☐MRI ☐Not sure ☐Other _____
☐	☐	Did you have any cuts or lacerations? Where? _____
☐	☐	Did you have any body bruising? (red / black / blue) Where? _____

YES	NO	
☐	☐	Did the airbag deployed? ☐Front ☐Left Side ☐Right Side
☐	☐	Did any of the front / side structures, such as side door, dashboard of your car, dent inward during the collision?
☐	☐	Did the side door touch your body during the collision?
☐	☐	Was the door(s) of your vehicle damaged to the point where you could not open the door?
☐	☐	Was your vehicle towed? If no, how bad was the damage? ☐Little ☐Moderate ☐Severe
☐	☐	Did police officer and/or emergency vehicles arrive at the scene? If Yes, was ticket issued? ☐Yes ☐No

Automobile Insurance Information

My Auto Insurance ☐Allstate ☐Geico ☐Farmers ☐Progressive ☐State Farm ☐Other _____

Other party's Insurance ☐Allstate ☐Geico ☐Farmers ☐Progressive ☐State Farm ☐Other _____

Claim # _____ Adjuster Name _____

Adjuster Phone: _____ Adjuster Fax _____

Patient Name: _____ **Date:** _____