LONE STAR FAMILY CHIROPRACTIC

7410 Golden Pond Pl. Suite 200 Amarillo, TX 79121
Phone: 806-322-2073 Fax: 806-322-2075
www.lonestarfamilychiro.com

For Office Use Only

Today's Date: _____

Name: _____ DOB: _____/_____/_____ Age: _____ SS#: _____-____-_____

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

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email Address: _____ Marital Status: M D S W

Employer/School: _____ Occupation: _____ Emp. /School Phone: _____-_____-_____ Emp Add: _____

Spouse: _____ Spouse's Employer: _____ Emergency Contact Name and Number: _____

How were you referred to our office?

☐Patient _____

☐News Ad ☐Yellow Pages ☐Spouse

☐Drive By ☐Other _____

Your Family Physician: _____ Physician Phone Number: _____-_____-_____

Insurance Carrier: _____ Primary Insured Name: _____

ID #: _____ Group #: _____ HSA Account or Flex Plan: ☐Yes ☐No

Secondary Insurance: _____ ID#: _____ Group #: _____

On a scale of 0 to 10, please rate your pain for each of the following areas:

Neck: _____ Mid back: _____ Low back: _____

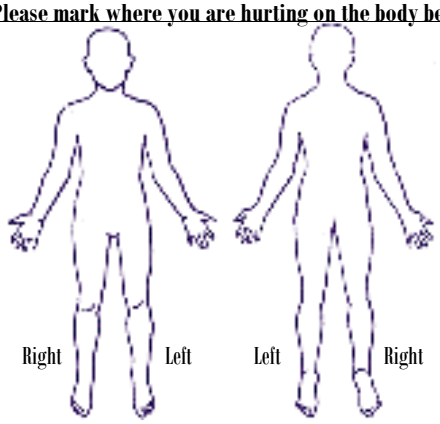
Shoulder/Arm: _____ Headaches: _____ Leg: _____

Pain Scale

0 1 2 3 4 5 6 7 8 9 10

None Little Medium Severe

Please mark where you are hurting on the body below:



Main Complaint Today: _____

_____

How long has the pain been there? _____

The Pain Is: (Please circle all that apply)

Numbness Tingling Pins & Needles Weakness Stabbing

Aching Stiffness Throbbing Burning Radiating

Sharp Dull Constant Comes & Goes

Complaints other than above: _____

_____

Check symptoms you have noticed:

☐ Headaches	☐ Tension	☐ Shortness of breath	☐ Face flushed	☐ Pins and needles in arms	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Fatigue	☐ Loss of balance	☐ Pins and needles in legs or toes	☐ Hands Cold
☐ Stiff Neck	☐ Dizziness	☐ Lights bother eyes	☐ Buzzing in ears	☐ Loss of Smell	☐ Stomach Upset
☐ Back Pain	☐ Head seems heavy	☐ Loss of memory	☐ Fainting	☐ Loss of Taste	☐ Cold Sweats
☐ Sleeping Problems	☐ Numbness in legs or toes	☐ Ears ring	☐ Numbness in fingers	☐ Diarrhea/Constipation	☐ Fever

Lone Star Family Chiropractic

Dr. Tyson Neill
7410 Golden Pond Pl. Ste. 200, Amarillo, TX 79121

Date of last physical examination: _____ Have you been treated for any health condition by a physician in the last year? □ Yes □ No

Family history of: Heart Disease Stroke Cancer Diabetes Arthritis Back Problems Disc Problems Other:_____

Have **you** ever been diagnosed with or suffered from... (Please check all that apply to **you**.)

□ Aids/HIV
□ Alcoholism Depression
□ Allergies
□ Anemia
□ Alcoholism
□ Appendicitis
□ Asthma
□ Bleeding Disorders
□ Broken/Fractured Bones
□ Cancer
□ Chemical Dependency
□ Congenital Disease
□ Depression
□ Diabetes
□ Eating Disorders
□ Emphysema
□ Epilepsy
□ Gall Bladder
□ Goiter
□ Gout
□ Heart Disease
□ Hernia
□ Herniated Disk
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Migraine Headaches
□ Miscarriage
□ Multiple Sclerosis
□ Neuropathy
□ Osteoarthritis
□ Osteoporosis
□ Pacemaker
□ Parkinson's disease
□ Pinched Nerve
□ Prostate Problems
□ Pneumonia
□ Polio
□ Prosthesis
□ Rheumatoid Arthritis
□ Shingles
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tumors/Growths
□ Ulcers
□ Other: _____
_____

Please list any **medications** you may be taking:

_____
_____
_____
_____

Please list any **vitamin supplements** you may be taking:

_____
_____
_____
_____

Do you drink alcoholic beverages: □Yes □No
How many per week? _____
Do you use any tobacco products? □Yes □No
How many per week? _____

Previous Surgeries: _____
_____

Previous Accidents or Injuries: _____
_____

How many **hours** a day do you spend.....
Sitting _____ Lifting _____
Computer work _____ Bending _____

Authorization & Release

I authorize payment of insurance benefits directly to Dr. Tyson Neill or Lone Star Family Chiropractic. I authorize Dr. Tyson Neill to release all information necessary to communicate with personal physicians and other healthcare providers and payers to secure the payment of benefits. I understand that I am responsible for all costs 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 be immediately due and payable.

The patient understands and agrees to allow Lone Star Family Chiropractic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning the privacy of your Patient Health Information. We encourage you to read the HIPPA notice, and if you would like a copy one can be made available to you at the front desk. If there is anyone you would not like to receive your medical records, please inform us.

Patient/Guardian's Signature: _____ Date: _____