Prime Condition PLLC
Dr. Stephanie Beavers
5240 North Tarrant Parkway
Suite H
Fort Worth, TX 76137

New Patient Information

Name _____

Sex _____ Date of Birth _____

Home Phone _____

Cell Phone _____

Work Phone _____

Address _____

City _____ State _____ Zip _____

Email Address _____

Marital Status_____ Spouse Name _____

Emergency Contact _____

Emergency Contact Phone _____

Emergency Contact Relationship _____

Referred By _____

Your Occupation _____

How many hours sitting? _____

How many hours physical? _____

Accident Information (<u>SKIP</u> this page if you were <u>NOT</u> involved in an accident)

Is your condition due to a(n):

____Auto Injury

____Work Injury

____Slip and Fall

____Other Accident (describe below)

_____

_____

_____

_____

Date of Accident _____

Place (City/State) _____

Auto/Work Insurance Company _____

Insured's Name _____

Insured's DOB _____

If Auto Injury, have you reported the accident to your insurance company?
___ No ___ Yes

Claim #_____

If Work Injury, have you reported the accident to your supervisor/boss?

___ No ___ Yes

Claim #_____

If Slip and Fall or Other Type of Injury, please describe:

_____

_____

_____

Do you have an Attorney for your Auto or Work Comp. injury?

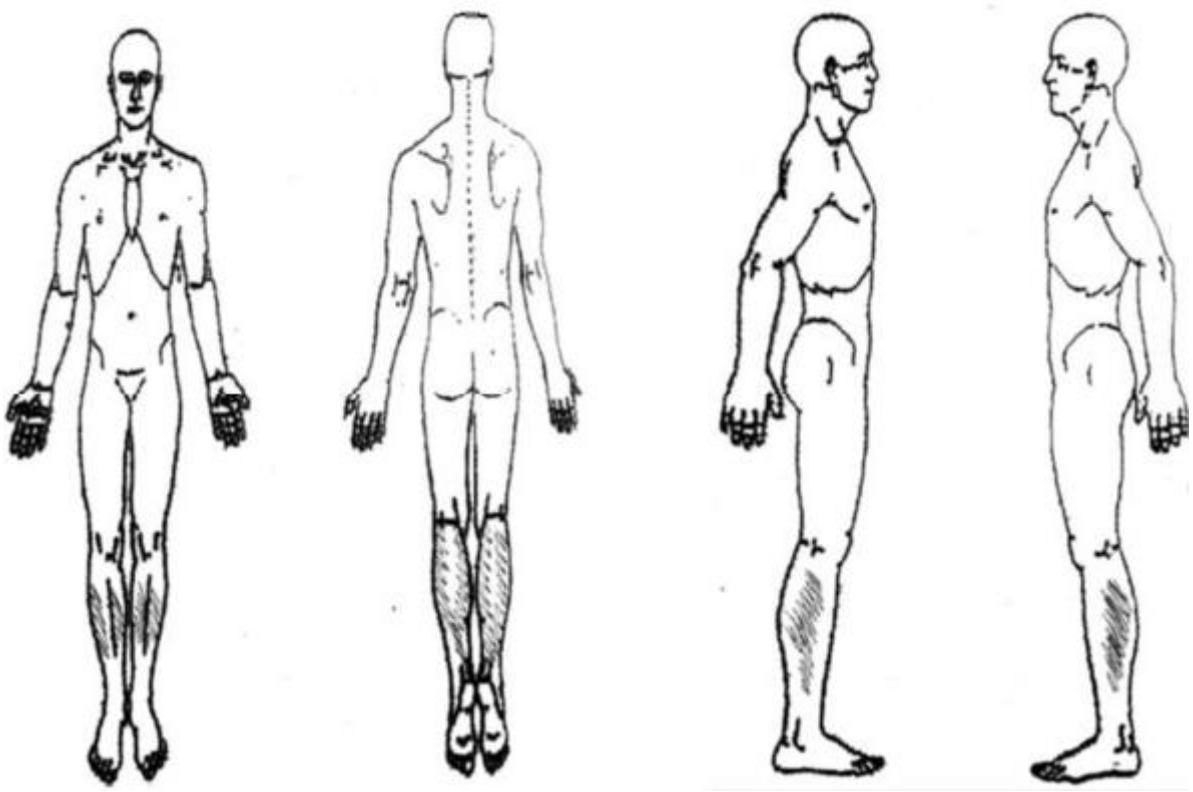
___ No ___ Yes

If yes, please provide attorney name, address and phone #

_____

_____

Indicate on the drawings below where you have pain/symptoms:



Current Complaint

Please list your worst complaint:

_____

_____

_____

_____

How long have you had it?

_____

Date of onset?

_____

How did it start?

_____

Please explain:

_____

_____

_____

What are you doing when you feel it most?

_____

_____

How long before you feel it?

_____

_____

Do daily activities aggravate the symptoms? ___ No ___ **Yes**

What other activities make it worse?

___ General Activity ___ Moving Wrong

___ Bending ___ Lifting

___Walking ___ Sports

___ Getting up from a chair ___ Working at a computer

___ Other: _____

___ Other: _____

<u>If the pain is sport related:</u>

How long have you been in this sport?

_____

_____

How many hours per week do you train?

_____

_____

Do you have rest days?

_____

_____

Does the pain travel anywhere?

_____

_____

How would you describe your pain?

Is the pain:

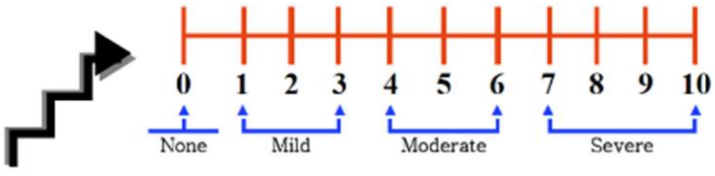
___ Constant (75-100% of the time)
___ Frequent (51-75% of the time)
___ Occasional (26-50% of the time)
___ Intermittent (1-25% of the time)

Is the pain:

___ Improving
___ Worsening
___ Staying the same

Is the pain:

___ Mild (1-3)
___ Moderate (4-6)
___ Severe (7-10)



Is the pain worse in:

___ AM
___ PM
___ After the day wears on
___ Steady
___ On and Off
___ Other: _____

Does it feel (check all that apply):

___ Dull ___ Achy

___ Tight ___ Stiff

___ Sharp ___ Stabbing

___ Numb ___Tingly

___ Shooting ___ Burning

___ Cramping ___ Other: _____

What makes it feel better (check all that apply):

___ Chiropractic adjustment ___ Physical therapy

___ Exercise ___ Prescription medication

___ Heat packs ___ Re-direct attention

___ Massage ___ Rest

___ Nothing ___ Stretching

___OTC medication ___ Work

___ Other: _____

___ Other: _____

Do you have reoccurring flare ups? ___ No ___ Yes

_____

_____

Have you seen another provider for this condition? ___ No ___ Yes

_____

_____

Have you had diagnostic imaging of this condition? ___ No ___ Yes

_____

_____

Current Health

Name of Primary Care Provider: _____

Phone number of Primary Care Provider:_____

List all CURRENT illnesses or diseases you have been diagnosed with (cancers, tumors, infections, diabetes, aneurysms, etc.):

_____

_____

_____

_____

_____

_____

If you are currently taking any prescription or nonprescription medications, please list them below with dosages:

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

(If needed, attach a written list of more.)

Do you have any allergies of ANY kind?

_____

_____

_____

_____

Please indicate your:

Height: _____

Weight: _____

Do you have trouble concentrating during the day? ___ No ___ Yes

_____

_____

_____

_____

Do you have trouble concentrating during your sport? ___ No ___ Yes

_____

_____

_____

_____

Have you noticed any other symptom that may or may not be related to chiropractic? ___ No ___ Yes

_____

_____

_____

_____

Health History

List any operations, surgeries or medical procedures:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

If you have ever had in the past or currently have any serious <u>illnesses,</u> please list:

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

If you have ever had in the past or currently have any serious <u>injuries,</u> please list:

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Have you ever been involved in any <u>car accidents</u>? ___ No ___ Yes

If yes, how many? _____

Please explain:

_____

_____

_____

_____

_____

Have you ever been involved in any <u>traumas?</u> ___ No ___ Yes

If yes, how many? _____

Please explain:

_____

_____

_____

_____

_____

Any current:

___ Loss of bowel control ___ Loss of bladder control

___ Seizures

___ Paralysis ___ Speech problems

___ Vision problems

___ Unexplained recent weight loss ___ Fever

___ Nutritional problems

___ Other: _____

Please list any significant family illnesses:

Mother: _____

Father: _____

Sibling: _____

When have you had spinal X-rays within the past five years?

_____

Location: _____

Have you been diagnosed with any blood/lymph disorders? ___ No ___ Yes

If yes, please list:

_____

_____

_____

Have you been diagnosed with osteoporosis or rheumatoid arthritis?

___ No ___ Yes

If yes, please list:

_____

_____

_____

Do you wear a Smart Watch or Fitbit? ___ Smart Watch ___ Fitbit

Please select one:

___ I have never smoked ___ Former smoker

___ Current smoker (_____ packs per day/ _____ packs per week)

Please select one:

___ I don't drink alcohol ___ Rarely drink ___ Social drinker

___Heavy drinker (_____ oz. per day/ _____ week)

Have you ever had chiropractic care: ___ No ___ Yes

If yes, last date of treatment: _____

Name of chiropractor: _____

What condition were you being treated for?

_____

_____

_____

What were your results?

_____

_____

_____

What are your overall expectations from your treatment with our doctor?

_____

_____

_____

_____

Do you have a pacemaker? ___ No ___ Yes If yes, please <u>ALERT</u> our doctor and/or chiropractor assistant.

<u>WOMEN ONLY</u>

Do you have a menstrual cycle? ___ No ___ Yes

Are they regular? ___ No ___ Yes

I hereby declare to the best of my knowledge, I am ___ or I am not ___ pregnant.

If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

I, the undersigned, hereby give my consent for the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic care. I also give my consent to the doctor to order x-rays (if needed) or to perform other diagnostic aids as he/she deems appropriate in my case.

Patient Signature: _____

Patient name (print): _____

Date: _____

If patient is a minor:

Guardian Signature:_____Date:_____

Guardian Name (print):_____

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Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, and if necessary, diagnostic x-rays on me (If the patient is a minor, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels is in my best interests at the time, based upon the facts then known.

I further understand that such chiropractic services may be performed by Prime Condition PLLC who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Stephanie Beavers the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

Print Patient's Name: _____

Patient's Signature: _____ Date _____/_____/_____

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Representative's Name: _____

Patient's Representative's Signature: _____ Date _____/_____/_____

Physician's Signature: _____ Date _____/_____/_____

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PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Prime Condition PLLC, and understand the situations in which this practice may need to utilize or release my medical records.

I also understand that I agreed to the use of those records when I applied for care at this office (my intake, medical history and informed consent to treat forms) on my initial visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

To be completed by the patient:

Print Patient's Name: _____

Patient's Signature: _____ Date _____/_____/_____

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

Print Patient's Representative's Name: _____

Patient's Representative's Signature: _____ Date _____/_____/_____