

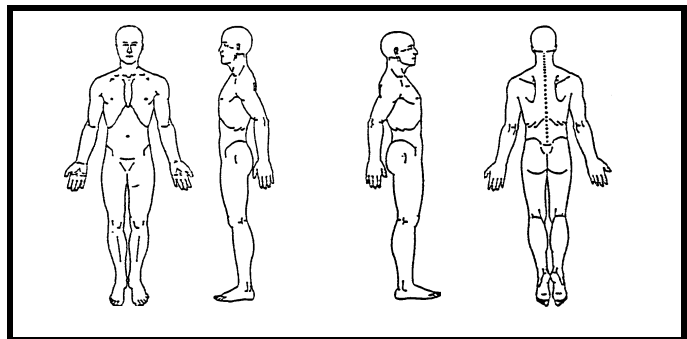
Houma-Thibodaux Spine & Rehabilitation Patient Health Questionnaire

Patient Name: _____	Date: _____
----------------------------	--------------------

1. When did your symptoms start: _____
2. Describe your symptoms and how they began: _____

3. Mark a (x) on the picture where you have pain or other symptoms:

4. How often do you experience your symptoms?
- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)



5. What describes the nature of your symptoms?
- Sharp Shooting
- Dull Ache Burning
- Numb Tingling

6. How are your symptoms changing?
- Getting Better
- Not Changing
- Getting Worse

7. How bad are your symptoms:
- ...at their worse (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)
- ...at their best (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

8. What activities make your symptoms worse? _____

 ...symptoms better? _____

9. Who have you seen for your symptoms?
- No One Physical Therapist
- Other Chiropractor Other: _____
- Medical Doctor _____

10. Have you had any of the following:
- X-rays (date) _____
- MRI (date) _____
- CT Scan (date) _____
- Other (date) _____

11. What do you hope to get from this visit/treatment? **(Select all that apply)**
- Reduce symptoms Explanation of condition/treatment How to prevent this from occurring
- Resume/increase activity Learn how to take care of this on my own Other: _____

Patient History

(Please check all symptoms you have ever had, even if they do not seem related to your current problem.)

<input type="checkbox"/> Headaches	<input type="checkbox"/> Muscular In coordination	<input type="checkbox"/> HIV/Aids	FEMALES ONLY
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Tumor	
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chronic Sinusitis	Other Health Issues
<input type="checkbox"/> Wrist/Hand Pain	<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Hip/Upper Leg Pain	<input type="checkbox"/> Kidney Stones/Disorder	<input type="checkbox"/> Smoking/Use of Tobacco	_____
<input type="checkbox"/> Knee/Lower Leg Pain	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Drug/Alcohol Dependence	_____
<input type="checkbox"/> Ankle/ Foot Pain	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Allergies	_____
<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/> Depression	
<input type="checkbox"/> Joint Swelling/Stiffness	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Systemic Lupus	
<input type="checkbox"/> Arthritis/Rheumatoid Arthritis	<input type="checkbox"/> Abnormal Weight Loss/Gain	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> General Fatigue	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Dermatitis/Eczema/Rash	

Indicate if an immediate family member has had any of the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Other: _____

List any medications, allergies, vitamins you are taking: _____

List any surgical procedures: _____

Patient's Signature: _____

Houma-Thibodaux Spine & Rehab.

Jake E. Bordelon D.C. Beau I. Porche D.C.

430 Corporate Dr., Houma, LA 70360 (985)873-8586 Fax(985)873-8565
2000 Audubon Dr., Ste. D, Thibodaux, LA 70301 (985)447-2225 Fax(985)625-2226

PATIENT INFORMATION

Date _____ Name _____ Male/Female _____ DOB _____
Address _____ City, St & Zip _____
Home ph. _____ Wk ph. _____ Cell ph. _____
Employer/School _____ SS# _____
Status: Single/Divorced/Widowed/Married Spouse's name _____
Emergency contact _____ Relationship _____ Ph. _____
How did you hear about our clinic? Newspaper Yellow Pgs. Sign Website Referral-by whom _____
Other _____

PATIENT FINANCIAL RESPONSIBILITY

Who is responsible for this account? Self Family member: _____ Other: _____
Method of payment: Cash Check Credit Card Insurance: _____
Policy/ID # _____ Group # _____ Insured _____
Insured DOB _____ Insured SS# _____ Relationship to insured _____

I, the undersigned, certify that I (or my dependent) have insurance with the above carrier and assign directly to Houma-Thibodaux Spine & Rehabilitation all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

PATIENT AUTHORIZATION FOR RECORDS REQUEST

I hereby authorize the release of the protected health information as indicated below:

I understand I may refuse to sign this authorization and that treatment and payment cannot be conditioned upon my completion of this form. I understand that this authorization may be revoked in writing except to the extent that your practice has acted in reliance thereon.

Information to the Used/Disclosed

____ Complete medical records ____ Lab results ____ X-rays ____ MRI's ____ Other _____

Purpose of the Use/Disclosure

____ Continued care by another health professional ____ Insurance ____ Attorney ____ School ____ Personal Review
____ Other _____

Entity or person To Whom the Use/Disclosure should be made _____

Signature _____ Expiration Date/Event _____

PATIENT CONSENT

I understand that some of my health information may be used and/or disclosed by the office to carry out treatment, payment, or health care operations, and that for more complete descriptions of such uses and disclosures, I should refer to the office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form. I understand that I may request restrictions on how my information is disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this consent, but only to the extent that the office has not taken action in reliance thereon and also proved that I do so in writing. I understand that for my protection, any request to amend my health information or to access my medical records must be made in writing.

Please sign after reading/agreeing to the conditions of the Patient Financial Responsibility, Authorization & Consent.

Signature _____ Date _____