MARSHALL BACK & BODY WELLNESS CENTER

Confidential Patient Information

Name_____ Social Sec. Number_____

Date of Birth_____ Age_____ Gender: M or F Marital Status_____ # Children____

Address_____
Address *City* *State* *Zip Code*

Home Phone #_____ Cell Phone_____ Email_____

_____
Your Occupation *Company Name* *City* *Work Phone*

_____
Spouse or Guardian's Name *Occupation* *Company Name* *City*

How did you hear about us?_____

Do you have health insurance? □Yes □No Company_____

If yes, please present your card(s) to the FRONT DESK for processing.

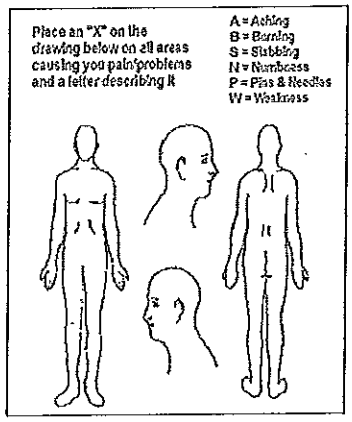
PATIENT CONDITION

Reason for Visit: _____

When did symptoms appear? _____

Briefly describe your MAJOR complaints: _____

_____



MARK AN "X" ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS OR TINGLING.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). _____

Type of Pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness
[ ] Aching [ ] Shooting [ ] Burning [ ] Tingling
[ ] Cramps [ ] Stiffness [ ] Swelling [ ] Other

How often do you have this pain?: _____

Is the pain constant or does it come and go?: _____

Does it interfere with your [ ] Work [ ] Sleep [ ] Daily Routine [ ] Recreation

Activities or movements that are painful to perform [ ] Sitting [ ] Standing [ ] Walking [ ] Bending
[ ] Lying down [ ] Running

Mark any areas that you have pain or have experienced pain in. Please leave lines BLANK this area is for the Dr.

HEAD & NECK

[ ] Headache _____
[ ] Neck pain with movement_____
[ ] Neck pain without movement_____
[ ] Neck feels out of place _____
[ ] Stiff neck _____
[ ] Muscle spasm in neck _____
[ ] Grinding sounds in neck _____
[ ] Popping sounds in neck _____
[ ] Radiation of pain into arms or hands _____

MID BACK

L	R	
[ ]	[ ]	Mid Back Pain _____
[ ]	[ ]	Pain between shoulder bladed _____

LOW BACK

[ ] Low back pain _____
[ ] Low back pain w/ radiation into buttocks or legs ____
[ ] Low back feels out of place _____
[ ] Muscle spasms _____
Comments:_____
Low Back Pain is worse when:
[ ] Working [ ] Bending [ ] Stooping [ ] Lifting
[ ] Coughing [ ] Standing [ ] Sitting [ ] At night

SHOULDERS

L	R	
[ ]	[ ]	Pain in shoulder joint _____
[ ]	[ ]	Pain across shoulders _____
[ ]	[ ]	Arthritis(diagnosed by a physician) _____
[ ]	[ ]	Tension in shoulders_____
[ ]	[ ]	Can't raise arm over head_____
[ ]	[ ]	Weakness in arms _____

PATIENT NAME: _____ PT ID: _____

HIPS, LEGS AND FEET

L	R	
[ ]	[ ]	Pain in hip _____
[ ]	[ ]	Pain in knee _____
[ ]	[ ]	Pain in back of leg _____
[ ]	[ ]	Pain in front of leg _____
[ ]	[ ]	Leg cramps _____
[ ]	[ ]	Sensation of pins & needles in legs _____
[ ]	[ ]	Numbness in feet _____
[ ]	[ ]	Cramps in feet _____
[ ]	[ ]	Pain in ankles _____
[ ]	[ ]	Swollen ankles _____
[ ]	[ ]	Foot pain _____
[ ]	[ ]	Numbness in toes _____
[ ]	[ ]	Weakness in legs _____

ARMS AND HANDS

L	R	
[ ]	[ ]	Pain in upper arm _____
[ ]	[ ]	Pain in elbow _____
[ ]	[ ]	Pain in forearm _____
[ ]	[ ]	Pain in hand _____
[ ]	[ ]	Pain in fingers _____
[ ]	[ ]	Sensation of pins & needles in arm _____
[ ]	[ ]	Sensation of pins & needles in hands _____
[ ]	[ ]	Hands cold _____
[ ]	[ ]	Swollen joints in fingers _____
[ ]	[ ]	Stiffness in fingers _____
[ ]	[ ]	Loss of grip strength/weakness _____

HEALTH HISTORY

What treatment have you already received for your condition? [ ] Medication [ ] Surgery [ ] Physical Therapy
[ ] Chiropractic [ ] None [ ] Other _____

Names of Doctors who have treated you for these conditions _____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____
Spinal Exam _____ Chest X-Ray _____
MRI, CT-Scan, Bone Scan _____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
AIDS/HIV	[ ]	[ ]	Goiter	[ ]	[ ]	Pinched Nerve	[ ]	[ ]
Alcoholism	[ ]	[ ]	Gonorrhea	[ ]	[ ]	Pneumonia	[ ]	[ ]
Allergy Shots	[ ]	[ ]	Gout	[ ]	[ ]	Polio	[ ]	[ ]
Anemia	[ ]	[ ]	Heart Disease	[ ]	[ ]	Prostate Problem	[ ]	[ ]
Anorexia	[ ]	[ ]	Hepatitis	[ ]	[ ]	Prosthesis	[ ]	[ ]
Appendicitis	[ ]	[ ]	Hernia	[ ]	[ ]	Psychiatric Care	[ ]	[ ]
Arthritis	[ ]	[ ]	Herniated Disk	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
Asthma	[ ]	[ ]	Herpes	[ ]	[ ]	Rheumatic Fever	[ ]	[ ]
Bleeding disorder	[ ]	[ ]	High cholesterol	[ ]	[ ]	Scarlet Fever	[ ]	[ ]
Breast lump	[ ]	[ ]	Kidney Disease	[ ]	[ ]	Stroke	[ ]	[ ]
Bronchitis	[ ]	[ ]	Liver disease	[ ]	[ ]	Suicide attempt	[ ]	[ ]
Bulimia	[ ]	[ ]	Measles	[ ]	[ ]	Thyroid Problems	[ ]	[ ]
Cancer	[ ]	[ ]	Migraines	[ ]	[ ]	Tonsillitis	[ ]	[ ]
Cataracts	[ ]	[ ]	Miscarriage	[ ]	[ ]	Tuberculosis	[ ]	[ ]
Chemical dependency	[ ]	[ ]	Mononucleosis	[ ]	[ ]	Tumor Growths	[ ]	[ ]
Chicken Pox	[ ]	[ ]	Multiple Sclerosis	[ ]	[ ]	Typhoid Fever	[ ]	[ ]
Diabetes	[ ]	[ ]	Mumps	[ ]	[ ]	Ulcers	[ ]	[ ]
Emphysema	[ ]	[ ]	Osteoporosis	[ ]	[ ]	Vaginal infections	[ ]	[ ]
Fracture	[ ]	[ ]	Pacemaker	[ ]	[ ]	Venereal disease	[ ]	[ ]
Glaucoma	[ ]	[ ]	Parkinson's	[ ]	[ ]	Whooping cough	[ ]	[ ]
						Other_____		

Last known: Height_____ Weight_____
How would you rate your diet? ◻ Excellent ◻ Good ◻ Fair ◻ Poor ◻ I don't know
How would you rate your exercise? [ ] None [ ] Moderate [ ] Daily [ ] Heavy
How would you rate your work activity? [ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy labor

Do you do any of the following:			
Smoke	[ ] NO [ ] YES	Packs/Day _____
Alcohol	[ ] NO [ ] YES	Drinks/Day _____
Coffee/Caffeine Drinks	[ ] NO [ ] YES	Cups/Daily _____
High Stress Level	[ ] NO [ ] YES	Reason _____

List any FALLS, HEAD INJURIES, BROKE BONES, DISLOCATIONS and SURGERIES and when you had them.

_____

_____

PATIENT NAME: _____ PT ID: _____

By signing below, I certify that my medical information above is correct to the best of my knowledge.

_____ _____
Date Patient Signature

FEMALE PATIENTS ONLY- Is it possible you are pregnant? ☐Yes ☐No
When was the date of your last menstrual cycle? _____

Consent to Receive Chiropractic Care
I hereby consent to the performance of examination, diagnosis, adjustments, other chiropractic procedures on me (or the patient named above, for whom I am legally responsible) by MaryBeth Asenime, D.C. and/or other professionals working at Marshall Back & Body Wellness Center who now or in the future treat me while employed by, working or associated with, or serving as an associate for Dr. Asenime. I understand and I am informed that, in the practice of chiropractic that there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I agree that if I suspect any adverse event that I will inform Dr. Asenime. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments I receive. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

By signing below, I understand the terms above and agree to the Consent to Receive Chiropractic Care.

_____ _____
Date Patient Signature

Records Release
At times it is necessary to request records such as examination results, MRI reports, etc. from other healthcare providers. We also send reports to your primary care physician and specialists to keep them informed of your current condition(s) and response to care.

By signing below, I understand the terms above and allow the release of my medical records for the purpose of communication about my health related condition(s) between Marshall Back & Body Wellness Center and my other healthcare providers.

_____ _____
Date Patient Signature

Assignment of Insurance Payments
I hereby instruct and direct my insurance company or their intermediaries to pay for services rendered to the order of Marshall Back & Body wellness Center and to be mailed to PO Box 131058, Houston, TX 77219 for the professional medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for services provided. **This is a direct assignment of my insurance benefits.** This payment will not exceed indebtedness to Dr. Asenime. I agree to cooperate with the Office of Dr. Asenime to pursue any third party that is responsible for any balance of said professional service charges. A photocopy of this Assignment shall be considered as effective and valid as the original document. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

By signing below, I understand the terms above and agree to the Assignment of Insurance Payments.

_____ _____
Date Patient Signature