Dr. Michael T. Martin DC

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South Houston Chiropractic

We truly hope you enjoy your experience here and welcome your suggestions for improvement.

Please complete this form and then return to the receptionist.

Date: _____ SSN: _____ File #: _____
Last Name: _____ Name: _____ M.I. _____
Prefers to be called: _____ Age: _____ Date of Birth: _____ ☐ M ☐ F

Home Address: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Cellular: _____
E-mail Address: _____
Occupation: _____ Employer: _____
Work Address: _____
City: _____ State: _____ Zip Code: _____
Spouse's Name: _____ Children: _____ Age: _____
Spouse's Employer: _____ Phone: _____
Spouse's Work Address: _____
City: _____ State: _____ Zip Code: _____
Emergency Contact: _____ Phone: _____

Have you ever received chiropractic care in the past? Y☐ ☐ NO When? _____
If yes, please give name of Chiropractor: _____
Please describe the reason for previous care: _____
Name of your Medical Doctor: _____
List the name of your health insurance company: _____
My insurance policy number is: _____

Reason(s) for seeking chiropractic care starting with the most severe:

Chief Complaint	Approximate Date Started:
1-	
2-	
3-	

Chiropractors are interested in helping your body function optimally. Frequently, there are events, injuries, or traumas that occur throughout life that affect the development and structure of your spine. Such altered function can influence the nervous system and may affect your general health.

Please answer the following to the best of your ability:

In general, would you say your health is (check one):

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your general health now?

☐ Much better now ☐ Somewhat worse now ☐ About the same

☐ Somewhat better now ☐ Much worse now

As a child:

Did you have any accidents, falls, traumas, or injuries? ☐ YES ☐ NO

If yes, please explain: _____

_____

Did you participate in any sport activities? ☐ YES ☐ NO

If yes, please explain: _____

_____

Health is affected by your nervous system, but is also affected by your environment, the foods you eat, and your lifestyle activities and habits.

Health/Risk Factors:		**Comments:**
Do you smoke?	☐ YES ☐ NO	
Do you drink alcohol?	☐ YES ☐ NO	
Do you have a healthy diet?	☐ YES ☐ NO	
Do you exercise regularly?	☐ YES ☐ NO	
Do you sleep well?	☐ YES ☐ NO	
Is your job stressful?	☐ YES ☐ NO	
Can you think of any other habit or activity that has a positive or negative effect on your health?	☐ YES ☐ NO	

Please indicate any medications you are currently taking:

☐ Blood pressure ☐ Muscle relaxants ☐ Insulin

☐ Blood thiners ☐ Stimulants ☐ Antibiotics

☐ Birth control pills ☐ Cholesterol lowering ☐ None

☐ Steroids ☐ Pain killers (including Aspirin)

☐ Others: _____

Name of nutritional supplements and/or dietary aids: _____

_____

Patient General Information Questionnaire

Patient Name: _____ Date: _____ File #: _____

Review of Systems, Please check any condition you have had in the past or have now:

Now	Past		Now	Past		Now	Past	
☐	☐	Back pain	☐	☐	Poor circulation	☐	☐	Menstrual problems
☐	☐	Neck Pain	☐	☐	Irregular heart beat	☐	☐	Pregnancy
☐	☐	Shoulder/arm pain	☐	☐	High blood pressure	☐	☐	Colon trouble
☐	☐	Hip/leg pain	☐	☐	Difficulty breathing	☐	☐	Stomach trouble
☐	☐	Sciatica	☐	☐	Asthma	☐	☐	Liver trouble
☐	☐	Arthritis	☐	☐	Prostate problems	☐	☐	Frequent infections
☐	☐	Headache	☐	☐	Difficulty urinating	☐	☐	Skin problems
☐	☐	Dizziness	☐	☐	Kidney problems	☐	☐	Easy bruising
☐	☐	Chest pain	☐					
☐	☐	None of the above	☐	☐	None of the above	☐	☐	None of the above

Have you ever? **Comments:**

Had any accidents, falls, traumas, or injuries: ☐ YES ☐ NO _____

_____

Been hospitalized: ☐ YES ☐ NO _____

_____

Hasd a broken bone: ☐ YES ☐ NO _____

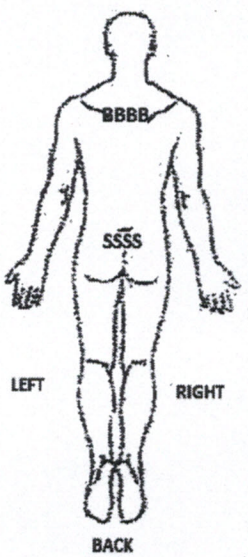
Been treated for an emotional disorder: ☐ YES ☐ NO _____

Been bedridden for more than a week: ☐ YES ☐ NO _____

Areas of injury or discomfort:

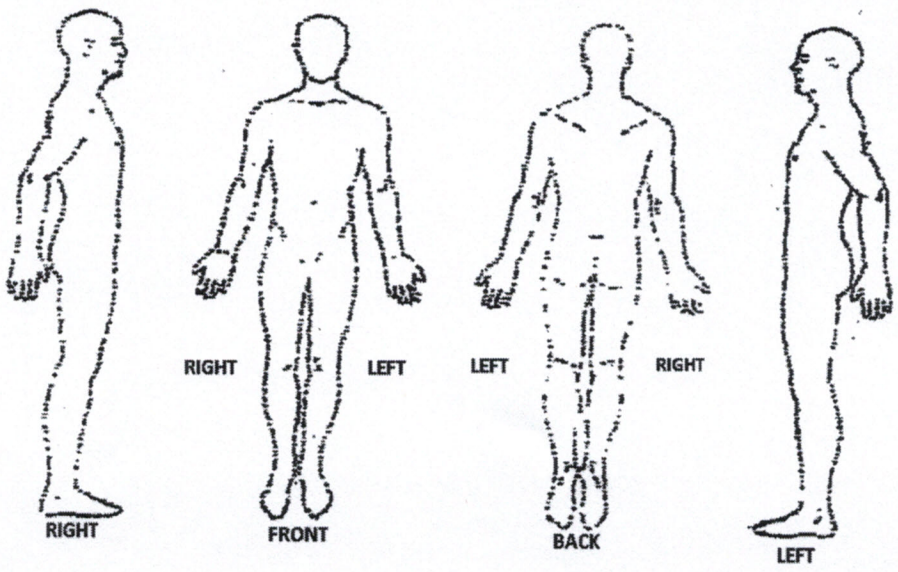
On the following chart please mark area(s) of injury or discomfort (see example). Mark all areas with the appropriate symbols and indicate the degree of pain on a scale from 1 (discomfort) to 10 (extreme pain).

Example:



NNNN- Numbness
PPPP-Pins and Needles
BBBB- Burning
AAAA- Aching
SSSS- Stabbing

Circle any area of pain not represented by a symbol.



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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for who I am legally responsible) by the doctor of chiropractic name above and/or licensed doctors of chiropractic who now or in the future treat me while employed by working or associated with serving as back up for the doctor of chiropractic named above, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personeel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are no guaranteed.

I understand and am informed that as in the practice of medicine, in the practic of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 facts then known, is in my best interest.

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

TO BE COMPLETED BY THE PATIENT OR PATIENT'S REPRESENTATIVE, IF NECESSARY,
E.G., IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED:

_____	_____	____/____/____
Print Patient's Name	Signature	Date
_____	_____	____/____/____
Representative	Relationship	Date

Witness to Patient's signature: _____ ____/____/____

The signed original is to be filed in the patient's file and a copy is to be given to the patient.