



5353 Alpha Rd Ste 110A, Dallas, TX 75240 • Tel. 972-490-9888 • Fax. 972-490-9830
www.woodwardchiro.com • woodwardchiro@yahoo.com

Date: _____
Name: _____ D.O.B.: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Ext.: _____
Type of Employment: _____ Any lifting involved? Yes or No
Cell Phone: _____ Email: _____
Do you have health insurance? Yes or No Name of Insurance Co.: _____
Marital Status: Single Married Divorced Widowed

Please circle any answers that may apply:

- 1. How did you hear about our office? Internet, Newspaper, Coupon, or Referred by:

- 2. Have you ever had a massage or chiropractic care before? Yes or No Did it help? Yes or No
How long did you receive the care? _____
- 3. Are you presently being seen by a doctor? Yes or No
- 4. Are you pregnant? Yes or No
- 5. Do you presently have any of the symptoms below? (Please circle any that apply)

- | | | |
|-----------------|-----------------------|-----------------|
| NECK PAIN | SHOULDER PAIN | MID BACK PAIN |
| LOWER BACK PAIN | RADIATING LEG PAIN | LEG NUMBNESS |
| NUMBNESS | TINGLING | HEADACHES |
| BLURRED VISION | RINGING OF EARS | NAUSEA |
| KNEE PAIN | HIP PAIN | ANKLE/FOOT PAIN |
| FIBROMYALGIA | OTHER SYMPTOMS: _____ | |

- 6. Do you have any of these medical conditions? (Please circle any that apply)
- | | | |
|-------------------------------|--------------------|----------------|
| HIGH BLOOD PRESSURE | LOW BLOOD PRESSURE | HEART PROBLEMS |
| DIABETES | CANCER | SEIZURES |
| BLOOD CLOTS | VARICOSE VEINS | BLOOD DISEASES |
| SKIN PROBLEMS | CONTAGIOUS DISEASE | |
| OTHER MEDICAL PROBLEMS: _____ | | |

- 7. Have you been involved in a motor vehicle accident within 1 year? Yes or No
- 8. Have you been involved or are you treating for a work injury? Yes or No
- 9. Have you been involved in any slip and fall or personal injury claim within 1 year? Yes or No
- 10. Are you interested in joining The Rub Club as a charter member? (lower cost) Yes or No
- 11. What type of massage do you prefer? LIGHT MEDIUM DEEP
- 12. Do you have any other persons you would like us to contact for a FREE MASSAGE?
Name of person: _____ Phone: _____

THANK YOU FOR HELPING US SERVE YOU! NOW RELAX AND ENJOY YOUR MASSAGE.

HIPAA & Our Privacy Pledge

At Woodward Chiropractic we are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition;
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services;
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing and mailed to 5353 Alpha Rd Ste 110A, Dallas, TX 75240, Attn: Dr Jonathan Woodward. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that I have been offered a copy of this notice.

Printed Name of Patient / Personal Representative

Date

Signature of Patient / Personal Representative

Description of Representative's Authority