11477 Custer Road Suite 106, Frisco, TX 75035
Office Phone/Fax: (972) 201-3445

Welcome to our office! ***PLEASE PRINT AND COMPLETE ALL SECTIONS***

Appointment Date: _____________ Referred By: ____
Name (first, middle, last) _________________________________Preferred Name: _________________
Address______________________________________City____________ State______ Zip__________
Home Phone (____)______________Work (____)_____________Cell (_____)______________________
Email: ________________________________ Date of Birth___/___/___ Age_______ □Male □Female
Occupation___________________________________Employer__________________________________
Marital Status: □M □S □W □D Name of Spouse:____
Names and Ages of children____

TELL US ABOUT ALL CURRENT AND PAST CONDITIONS:
Please mark, in front of each statement **ANY** that apply to you. Place and **"C"** for any **current conditions** and, **"P"** for any **past conditions** that are no longer an issue. **If it does not apply to you, please leave it blank**.

____Neck Pain or Stiffness R/L	____ Headaches/Migraines	____ Trouble Concentrating	____ Impotence
____Upper Back Pain or Stiffness R/L	____Asthma	____ Trouble Sleeping	____ Prostrate Problems
____Mid Back Pain or Stiffness R/L	____ Lung Problems	____ Excessive Sweating	____ Menopausal Problems
____Low Back Pain or Stiffness R/L	____ Difficulty Breathing	____ Cancer Type:__________	____ Menstrual Cycle Problems
____ Hip Pain or Stiffness R/L	____Chest Pain	____ Learning Disability	____ Kidney Trouble
____Shoulder Pain or Stiffness R/L	____ Heartburn	____ Nervous/Irritable	____ Frequent Urination
____Foot Pain Stiffness R/L	____ Heart	____ Loss of Memory	____ Bedwetting
____Wrist Pain or Stiffness R/L	____ Digestion Problems	____ Dizziness/Loss of Balance	____ Diabetes
____ Legs / Feet / Toes R/L	____ Gallbladder Problems	____ Arthritis	____ Liver Trouble
____Elbow Pain or Stiffness R/L	____ Colon Trouble	____ Epilepsy/Convulsions	____ Hepatitis
____ Swollen or Painful Joints	____ Diarrhea/ Constipation	____ Knocked Unconscious	____ High/Low Blood Pressure
____Knee Pain or Stiffness R/L	____ Hemorrhoids	____ Frequent Ear Infections	____ Sinus / Allergies
____Head/Shoulders Feel Heavy/Tired	____ Skin Problems	____ Ringing in Ear R/L	____ Frequent Colds/Flu
____Pain with cough/sneeze or strain	____ Anemia	____ Hearing Loss R/L	____ AIDS/HIV
____Difficulty with (circle all that apply) Standing/Walking/Sitting/ Bending/Lifting/Twisting	____ Jaw Pain/Clicking or Popping R/L	____ Emotional/Mental Disorders	____ Fracture/Dislocation of Bones:_________________
____ Arms/ Hand/Fingers R/L	____ Other:	____ Other:	____ Other:

When did you last see a chiropractor? ____________Dr. Name:________________________________
For what reason? ____
What spinal maintenance programs were you given to maximize the stability of your spine?
____
Did you follow the Doctor's recommendations? □ Y □ N If no, Why not? _______________________
Why are you changing chiropractors? ____

Patient Name: ____ Date: ____________

TELL US ABOUT YOUR PRESENT AND PAST HEALTH CONDITION(S)

1. Primary Complaint(s): ____
   ____
2. How long have you suffered with your primary complaint(s)? ____
   ____
3. What have you tried to do to get rid of this problem that DID NOT work? ____________________________
   ____
4. On a scale of 1 to 10, with 10 being the most severe, rate your current level of pain for your chief complaint: ______ What level would you rate your pain at its worst? ______ At its best? ______
5. Have you become discouraged about handling this problem? □ Yes □ No
6. Does this problem interfere with the following areas of your life?
   - Family: □ Yes □ No If yes, please explain: ____
   - Work: □ Yes □ No If yes, please explain: ____
   - Hobbies: □ Yes □ No If yes, please explain: ____
   - Life: □ Yes □ No If yes, please explain: ____
7. Does handling this problem cause stress for you? □ Yes □ No
8. What activities make this problem worse? ____
9. What gives you some temporary relief? ____
10. What is the pattern of this problem? (circle one) Constant, Intermittent, Occasional, Cyclic
11. What effect does this problem have on your body functions? ____________________________ _______
    ____
12. How did the problem start? ____
13. Is your condition due to : □ work condition □ auto accident □ other ________________________________
14. If accident related give date and description of accident: ____
15. Name other type of doctor you have seen for this condition: what was done and for how long?
    ____
16. Tell us about your past medical history: What? When? Results?
    - Surgeries: ____
    - Hospitalizations: ____
    - Major Illness: ____
17. List any medications you take (prescription & non-prescription) and why you take them:
    ____
    ____
18. Do you have any other problems/complaints? □ Yes □ No If yes, please explain:
    ____
19. Is there any other information you would like us to know? □ Yes □ No If yes, please explain:
    ____
20. Family Health History:
    Please list any known diseases, conditions or past health problems of your family members:
    - Father:____
    - Mother: ____
    - Siblings: ____
    - Grandparents:____
21. Do you have any children with health problems that you are aware of or that concern you? □ Yes □ No
    If so what are they? ____

22. Secondary Complaint if applicable:____
____
23. How long have you suffered with your secondary complaint? ____
____
24. What have you tried to do to get rid of this problem that DID NOT work? ____________________________
____
25. On a scale of 1 to 10, with 10 being the most severe, rate your current level of pain for your secondary complaint: ______ What level would you rate your pain at its worst? ______ At its best? ______
26. Have you become discouraged about handling this problem? □ Yes □ No
27. What activities makes it worse? ____
28. What gives you some temporary relief? ____
29. What is the pattern of this problem? (circle one) Constant, Intermittent, Occasional, Cyclic
30. What effect does this problem have on your body functions? _______________________________________
____
31. How did the problem start? ____

TELL US ABOUT YOUR HEALTH GOALS

1. What are your health goals? ____
2. How do you expect to achieve these goals? ____
3. What are you expectations of this office? ____
4. How do you want us to handle your problem?
   ___Temporary Relief (help the symptom, but do not fix the cause of the problem)
   ___Maximum Correction (correct the cause of the problem for maximum stability in the future)
5. On a scale of 1-10 (10 being the **MOST**, and 1 being the **LEAST):**
   ____How committed are you to being at your maximum health potential?
   ____How important is it for your family to be at their optimum health potential?
   ____How committed are you to preventing arthritis and maximizing your spinal stability?
6. What are your favorite hobbies or activities? ____
   ____
7. What activities are you looking forward to doing in retirement?
   ____

I verify that all of my information is correct and that I have completed all questions with as much information as is possible.

Patient’s Signature: ____ Date: ______________

Parent/Guardian’s Signature: ____________________________________ Date: ______________

Relationship to Patient: ______________

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RELEASE AND CONSENTS

AUTHORIZATION FOR DIAGNOSIS AND TREATMENT
I authorize Dr. Adam Sheek, DC and whomever he may designate as an assistant to administer diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Responsible Person: ____

Relationship of responsible person: ____________________

CONSENT TO X-RAY EXAMINATIONS
If and when deemed necessary, I do hereby consent to x-ray examination.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.
Last Menstrual Period Date __________________________

Signature of Responsible Person: ___________________________________ Date: _______________

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize Dr. Adam Sheek, licensed Doctor of Chiropractic in the state of Texas, to administer treatment as deemed necessary to my Son/Daughter/Other: ___________

Child's Name: ____

Signature of Guardian: ____ Date: ______________

Worker's Compensation and Personal Injury:

INSURANCE ASSIGNMENT OF BENEFITS
I hereby instruct and direct my personal injury protection carrier and/or my auto insurance carrier and any liability carriers of any and all person(s) at fault of my injuries, and my attorney to DIRECTLY pay in full to Life Changing Chiropractic, LP under current insurance policy as payment towards the total charges for the services rendered to me. This is a direct assignment of my rights and benefits under my policy. I further direct my personal injury protection carrier and all other insurance companies involved, to pay Life Changing Chiropractic, LP directly, overriding any and all powers of attorney which may have been or may be submitted by my attorney. A photocopy of this assignment shall be considered as claims paid, to my insurance companies and/or my attorney.

I have read, understand, and agree to this information:

Signature of Responsible Person: ____Date:_____________

Witness:____

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NOTICE OF PRIVACY PRACTICES

Dr. Adam Sheek, D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object
We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

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Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by, Dr. Adam Sheek, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

(You May Refuse To Sign This.) THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON January 1, 2014

Printed Patient Name ______________________________ Date ______________

Signature ______________________________

Printed Name of Parent/Guardian ______________________________

Signature of Parent/Guardian ______________________________