1404 Rice Rd., Ste. 400 Tyler, TX 75703
Ph. (903) 581-4393 FX: (903) 581-8511

HOPSON CHIROPRACTIC

Today's Date_____

Name _____ **Birth date** _____ **Age**_____ **Gender** ❑ **M** ❑ **F**

Address _____ **City** _____ **State** _____ **Zip** _____

Preferred Name_____**Mom's Name** _____**Dad's Name** _____

Mom's Phone_____**Dad's Phone**_____**Home Phone**_____

Mom's Employer_____**Mom's Occupation**_____

Dad's Employer_____**Dad's Occupation** _____

Referral Source_____ **Name of Medical Doctor**_____

e-Mail Address _____ **Have you been to a chiropractor before?** □ **No** □ **Yes**

Emergency Contact _____ **ph #** _____

- **I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.**
- **I authorize Hopson Chiropractic to release and / or request records to or from other providers as may be necessary.**
- **I understand I am responsible for all bills incurred in this office.**
- **I authorize assignment of my insurance benefits (if applicable) directly to the provider.**
- **Person responsible for this account if other than the patient?**_____
- **I understand that after any initial promotional services all care is rendered at usual and customary fees.**
- **For my balance my preferred payment method is:** ❑ **Cash** ❑ **Check** ❑ **Credit Card** ❑ **Car/Work Ins.**

_____ _____

Patient / Parent Signature **(This represents a long term authorization for all occasions of service)** **Date**

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

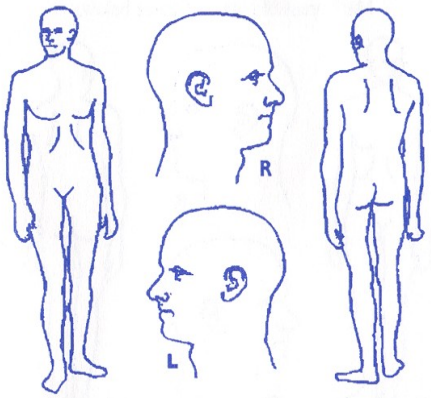
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark All areas of concern.



HOPSON CHIROPRACTIC

1404 Rice Rd., Ste. 400 Tyler, Tx. 75703
Ph: (903) 581-4393 FX: (903) 581-5811

GENERAL HEALTH HISTORY

Patient Name_____ ***Mark the conditions that apply to you.***

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. **List any medications being taken:**_____

2. **Number of courses of Antibiotics child has taken in the last 6 mo.**_____ **Total during lifetime**_____

3. **Name of Pediatrician and Other Doctors:**

_____

4. **Date of Last Visit** _____/_____/_____ **Reason:**_____

5. **Name of Obstetrician/Midwife:**_____

6. **Location of Birth:** ❑ **Hospital** ❑ **Birthing Center** ❑ **Home**

7. **Complications During Pregnancy:** ❑ **No** ❑ **Yes Explain**:_____

8. **Ultrasounds During Pregnancy:** ❑ **No** ❑ **Yes How Many**:_____

9. **Medication During Pregnancy / Delivery** ❑ **No** ❑ **Yes List**:_____

10. **Cigarette / Alcohol Use during Pregnancy:** ❑ **No** ❑ **Yes**

11. **Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":** ❑ No ❑ Yes, Name_____

PAST HISTORY

12. **List any past auto collisions:**_____ **Was any care received?**_____

13. **List any past falls bumps bruises:** _____ **Was any care received?**_____

14. **List any past sport, recreational, or home injuries:**_____

15. **Please describe any past conditions and treatment received:** _____

_____

16. **Please list any past hospitalizations and surgeries:** _____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Hopson Chiropractic

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

Chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Hopson Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-_____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ *Witness Initials*

Patient or Authorized Person's Signature Date

Doctor Signature

_____Date_____

Hopson Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call William Hopson at (903) 581-4393 If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

*Patient initials: _____**-retaining page 1 of 2***

Hopson Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Hopson Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	
_____	_____	
Doctor	Date	