



RETURN TO HEALTH

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

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Patient Signature: _____ Date: _____

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COMPLETE HISTORY FORM (Please try to answer all questions on both sides. This information will be treated as confidential.)

Name _____ Today's Date ____/____/____
 Date of birth ____/____/____ Age ____

PAST HEALTH HISTORY Month & year of last yearly physical ____/____ Never
 Have you ever had any of the following conditions? Check "NOW" if you have problem NOW. Check "PAST" if you had problem in the PAST. Check "NEVER" if you have NEVER HAD this problem.

	Now	Past	Never		Now	Past	Never		Now	Past	Never
Anemia/blood disease				Tuberculosis				Kidney disease			
Thyroid trouble				Pneumonia				Back pain			
Diabetes				Stomach ulcers				Epileptic seizures			
Rheumatic fever				Liver disease				Alcohol or drugs			
High blood pressure				Jaundice				Auto injury			
Heart problems				Cancer				Work injury			

List medications you take regularly? _____
 What drugs are you allergic to? _____
 Have you had all your "shots" (immunizations)? Yes No
 Name and address of previous family doctor. _____
 Do you want to be notified when your yearly physical & blood tests are due? Yes No
 Please list any SERIOUS illnesses, hospitalizations, cancers, or surgeries you have had.

Date	Illness or Operation	Doctor and/or Hospital	Mark X and enter Date if you have had.
			<input type="checkbox"/> 19__ X-rays of _____
			<input type="checkbox"/> 19__ Scan of _____
			<input type="checkbox"/> 19__ Colon tests
			<input type="checkbox"/> 19__ Breast x-rays
			<input type="checkbox"/> 19__ Heart tests
			<input type="checkbox"/> 19__ Pneumonia shot
			<input type="checkbox"/> 19__ Yearly physical
			<input type="checkbox"/> 19__ Yearly blood tests

FAMILY HEALTH ("Blood" relations only) Check "✓" if adopted.

Relative	Names	Age	Sex	Health Problems	If dead, cause of death	Age	Has any relation had	Yes	No
Father			M				Tuberculosis		
Mother			F				Heart disease		
Brothers & Sisters							High blood pressure		
							Alcoholism		
							Kidney disease		
							Diabetes		
							Strokes		
Children							Epilepsy		
							Nervous breakdown		
							Allergies or Asthma		
							Anemia		
						Cancer			

Please turn page! Please fill out the back of this sheet!

Check "✓" any **SERIOUS** problems you have now or have had in the past. Check "NOW" if you have problem NOW. Check "PAST" if you had problem in the PAST. Check "NEVER" if you have NEVER HAD this problem.

now			past			never			now			past			never		
Always Tired						Chills						Always Hungry					
Need Complete Yearly Physical?						Very Thirsty						Difficulty Sleeping					
Need Yearly Blood Tests?						Night Sweats						Bleeding Tendency					
Loss of Appetite						Warm "Blooded"						Growths, Tumors, Lumps					
Loss of Weight						Cold "Blooded"						Number of Alcoholic Drinks/Day					
Want Weight Loss Program?						Skin Trouble						Use/used Marijuana/Drugs					
Fever						Fainting or Dizziness						Need AIDS Test?					
HEAD & NECK																	
Allergies						Ever had Allergy Tests?						Itchy Eyes					
Headaches						Need Allergy Tests?						Frequent Colds					
Eye Trouble						Nasal Congestion						Sore Throat					
Hearing Difficulty						Nose Bleeds						Lumps in Neck					
Earaches						Congested or Runny Nose						Neck Pain					
Sinus Trouble						Sore Tongue						Sneezing Spells					
RESPIRATORY																	
Cough						Wheezing						Cigarette smoking					
Cough up phlegm						Shortness of breath						Number per day					
Cough up blood						Date of last TB test						Date of last chest x-ray					
CARDIOVASCULAR																	
Shortness of breath walking						Racing/skipping heart beat						Pains in Legs Feet (circle)					
Shortness of breath at night						Heart murmur						Poor circulation in legs					
Chest pains or pressure						Date last electrocardiogram						Cold feet, leg cramps					
High blood pressure						Swelling of ankles						Phlebitis (inflammation of veins)					
DIGESTIVE																	
Difficulty swallowing						Abdominal pain						Bloody bowel movements					
Heartburn						Gas & Bloating						Black bowel movements					
Nausea						Constipation						Do you take laxatives?					
Vomiting						Diarrhea						Any foods cause indigestion?					
Vomiting blood						Belching						Anal tags or growths					
Lump in throat						Blood on toilet paper						Hemorrhoids					
URINARY																	
Need to urinate often						Genital growths or warts						Getting up at night to urinate					
Painful urination						Wetting pants or bed						Weak urine stream					
Blood in urine						Difficulty starting urine						Have to run to the bathroom					
BONE AND JOINTS																	
Pain, stiffness, joint swelling						Have you had broken bones?						Back pain Neck pain (circle)					
Loss of joint movement						Foot trouble (warts or corns)						Do you need physical therapy?					
NERVOUS SYSTEM																	
Forgetfulness						Abnormal sensations, numbness						Difficulty walking					
Nervousness						Loss of balance						Tremors, shaking					
Depression						Clumsiness						Muscle weakness					
Frequent thoughts of suicide						Spells of any kind						Sexual difficulties of any type					
Poor concentration						Worry too much						Hot flashes					
Crying spells						Family marital problems						Irritable, feel like screaming					
SKIN																	
Warts hands feet other						Tatoos						Ingrown toe nails					
Moles						Rashes						Corns on feet					
Skin growths						Spots or veins on face						Veins on legs					
WOMEN ONLY																	
Irregular menstruation						Have you passed menopause?						Number of pregnancies					
Painful menstruation						Abnormal discharge or itching						Number of miscarriages					
Very heavy periods						Do you take birth control pills?						Date of last menstrual period					
Bleeding between periods						Any trouble with breasts						Date of last yearly pap smear					
Are you pregnant?						Hysterectomy						Need wrinkle laser surgery				Yes	No

What is your main problem today? _____

What other problems do you have not listed above? _____

Doctor's signature _____

Name _____

Fear Avoidance Beliefs Questionnaire (Physical Activity)

Here are some of the things other patients have told us about their pain. For each statement please mark the number from 0-6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree			Unsure		Completely Agree	
My pain was caused by physical activity	0	1	2	3	4	5	6
*Physical activity makes my pain worse	0	1	2	3	4	5	6
*Physical activity might harm my back	0	1	2	3	4	5	6
*I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
*I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

FABQ(PA) Score: _____

Greater than 19 Less than 12 (For * questions only)

Fear Avoidance Beliefs Questionnaire (Work)

The following statements are about how your normal work affects or would affect your back.

	Completely Disagree			Unsure		Completely Agree	
*My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
*My work aggravated my pain	0	1	2	3	4	5	6
I have a claim for compensation for my pain	0	1	2	3	4	5	6
*My work is too heavy for me	0	1	2	3	4	5	6
*My work makes or would make my pain worse	0	1	2	3	4	5	6
*My work might harm my back	0	1	2	3	4	5	6
* I should not do my regular work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
*I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
I do not think that I will ever be able to go back to work	0	1	2	3	4	5	6

FABQ(W) Score: _____

Greater than 34 Less than 19 (For * questions only)

Date _____ Scorer: _____
(Signature)



RETURN TO HEALTH

4474 Spring Valley Rd.
Farmers Branch, TX 75244
(P): (469) 677-0076
(F): (469) 677-0195

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of land-based and aquatic physiotherapy on me (or on the patient named below, for whom I am legally responsible) by Dr. Andrew Garrett, DC and/or other licensed doctors of chiropractic who now or in the future work at Return to Health, LLC.

I have had an opportunity to discuss with Dr. Andrew Garrett, DC and/or with other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice 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 health care providers at Return to Health, LLC to be able to anticipate and explain all risks and complications, and I wish to rely upon my healthcare providers to exercise reasonable judgment during the course of the procedure, based upon the information I have provided to them and the facts then known by my healthcare providers.

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 at Return to Health, LLC.

Patient Signature _____ Date _____

Witness Signature _____ Date _____



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HIPAA AUTHORIZATION FORM

I understand that under the Health and Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Most specifically to: (1) obtain payment from designated third-party payers, (2) conduct normal health care operations such as quality assessments or evaluations, prior authorizations, and physician certifications.

By my signature below, I consent to, and acknowledge that the healthcare providers at Return to Health, LLC may use and disclose my Protected Healthcare Information (PHI) to carry out the following:

1. Plan and provide for my care and treatment
2. Communicate to other healthcare professionals who may contribute or participate in my care and treatment
3. Obtain authorization, confirm service provided and collect payment from third-party payers
4. Perform routine healthcare operations such as the review of records from healthcare professionals

I also consent to Return to Health, LLC to:

1. Leave a message at my phone number on file to assist the practice in carrying out routine healthcare operations such as appointment reminders, insurance items and call pertaining to my clinical care
2. Mail to my address on file any items that assist the practice in carrying out routine healthcare operations such as appointment reminders, test results, patient information forms and patient statements.

INITIALS: _____

I understand that I have the right:

1. To request restrictions as to how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment or healthcare operations, and that the healthcare providers at Return to Health, LLC is not required to agree to the restrictions requested
2. To review the Return to Health, LLC's Notice of Privacy Practices and acknowledge that a copy has been given to me
3. To revoke this consent in writing, except to the extent that Return to Health, LLC may have already made PHI available to obtain payment from designated third-party payers or conduct normal health care operations prior to this request.

I acknowledge that I have read and understand all the above information and have answered the questions with complete and up-to-date information.

Signature _____ Date _____



RETURN TO HEALTH

4474 Spring Valley Rd
Farmers Branch, TX 75244
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(F): (469) 677-0195

Authorization to Release Medical Records Acknowledgement

I Understand that:

- This Authorization is voluntary, and I have the right to refuse to sign it.
- This Authorization will remain in effect for one year from the date of the signature below unless you specify a different date here: _____ (date).
- If I sign this Authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice. Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the Authorization.
- The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
- Once signed, the Practice will provide me with a copy of this Authorization.

Signature of patient/guardian _____

Date _____



RETURN TO HEALTH
 4474 Spring Valley Rd
 Farmers Branch, TX 75244
 (P): (469) 677-0076
 (F): (469) 677-0195

Authorization to Release Medical Records

**TITLE 22 EXAMINING BOARDS
 PART 9 TEXAS MEDICAL BOARD
 CHAPTER 165 MEDICAL RECORDS
 RULE §165.2 Medical Record Release and Charges**

Deadline for Release of Records. The requested copies of medical and/or billing records or a summary or narrative of the records shall be furnished by the physician within 15 business days after the date of receipt of the request for furnishing the information

Patient Name _____ Date of Birth _____

Claim Number(s)/DOI: _____

This information is to be REQUESTED FROM:

Agency/Business Name _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

This information is to be DISCLOSED TO:

**Return to Health, LLC
 4474 Spring Valley Rd.
 Dallas, TX 75254
 (P): (469) 677-0076
 (F): (469) 677-0195**

For the purpose of (please check one): Moving Changing provider At the request of the individual
 Consultation Insurance change Other (please describe) _____

Information to be disclosed:

Office notes for date(s) of service _____

X-ray reports of _____ for date(s) of service _____

MRI reports of _____ for date(s) of service _____

CD(s) containing images of above marked studies Photographs or other images

Complete healthcare record Other (please describe) _____

Special instructions: _____

Signature of patient/guardian _____ Date _____