



PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature:

Today's Date:

File #:



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WELLNESS CENTER LLC

"Remember your health outcomes are based on your health choices!"

Dr. Tray Andrews D.C.
www.lakehoustonwellness.com

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F

Home Address: _____

City, State, Zip: _____ Home # () _____

Email Address: _____ Cell # () _____

Birth Date: ____/____/____ SSN: ____-____-____ Marital Status: S M D

Names/Ages of Children:

Occupation: _____ Employer Name _____

Spouse's Name: _____ Phone: () _____

Spouse's Employer: _____

Occupation: _____

How were you referred to this office?

PURPOSE OF THIS VISIT

Reason for this visit: _____

Main Complaint: _____

Is this purpose related to an auto accident / work injury? Yes No If so, when: _____

When did this condition begin? ____/____/____ Did it begin: Gradual Sudden Progressive

What activities aggravate your symptoms?

Is there anything, which has relieved your symptoms? Yes No Describe:

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ___Arm ___Leg ___ Does not radiate

Is this condition getting worse? Yes No



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How often do you experience these symptoms throughout the day? _____

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine

Explain: _____

Have you experienced this condition before? Yes No

If so, please explain:

Who have you treated for this before? Yes No

If so, please explain:

Please list any health conditions not mentioned:

Please list any medications currently taking and their purpose:

Please list all past surgeries:

Please list all previous accidents and falls:

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? _____ When? _____

Reason for visits:

How did you respond?

Did your previous chiropractor take before and after x-rays? Yes No

Did you know posture determines your health? Yes No

Are you aware of any of your poor posture habits? Yes No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? Yes No

Explain: _____



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The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing “hump” at the base of your neck? Yes No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running, Jogging, Weight Training, Cycling, Yoga, Pilates, Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)?

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a “hunched forward” posture starting in the neck and progressively moving down your spine weakening the entire body).

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (Gray's Anatomy, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

		<i>Please Check Below</i>					
		Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction			
CERVICAL SPINE	1st THORACIC	1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	<input type="checkbox"/> headaches, <input type="checkbox"/> nervousness, <input type="checkbox"/> insomnia, <input type="checkbox"/> head colds, <input type="checkbox"/> high blood pressure, <input type="checkbox"/> migraine headaches, <input type="checkbox"/> nervous breakdowns, <input type="checkbox"/> amnesia, <input type="checkbox"/> chronic tiredness, <input type="checkbox"/> dizziness.			
		2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	<input type="checkbox"/> sinus trouble, <input type="checkbox"/> allergies, <input type="checkbox"/> pain around the eyes, <input type="checkbox"/> earache, <input type="checkbox"/> fainting spells, <input type="checkbox"/> certain cases of blindness, <input type="checkbox"/> crossed eyes, <input type="checkbox"/> deafness.			
		3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	NECK REGION	<input type="checkbox"/> neuralgia, <input type="checkbox"/> neuritis, <input type="checkbox"/> acne or pimples, <input type="checkbox"/> eczema.		
		4C	Nose, lips, mouth, eustachian tube.		<input type="checkbox"/> hay fever, <input type="checkbox"/> runny nose, <input type="checkbox"/> hearing loss, <input type="checkbox"/> adenoids.		
				5C	Vocal cords, neck glands, pharynx.	<input type="checkbox"/> laryngitis, <input type="checkbox"/> hoarseness, <input type="checkbox"/> throat conditions such as sore throat or quinsy.	
				6C	Neck muscles, shoulders, tonsils.	<input type="checkbox"/> stiff neck, <input type="checkbox"/> pain in upper arm, <input type="checkbox"/> tonsillitis, <input type="checkbox"/> chronic cough, <input type="checkbox"/> croup.	
				7C	Thyroid gland, bursae in the shoulders, elbows.	<input type="checkbox"/> bursitis, <input type="checkbox"/> colds, <input type="checkbox"/> thyroid conditions.	
THORACIC SPINE	1st LUMBAR	1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	MID-BACK	<input type="checkbox"/> asthma, <input type="checkbox"/> cough, <input type="checkbox"/> difficult breathing or shortness of breath, <input type="checkbox"/> pain in lower arms and hands.		
		2T	Heart, including its valves and covering; coronary arteries.		<input type="checkbox"/> functional heart conditions and certain chest conditions.		
				3T	Lungs, bronchial tubes, pleura, chest, breast.	<input type="checkbox"/> bronchitis, <input type="checkbox"/> pleurisy, <input type="checkbox"/> pneumonia, <input type="checkbox"/> congestion, <input type="checkbox"/> influenza.	
				4T	Gall bladder, common duct.	<input type="checkbox"/> gall bladder conditions, <input type="checkbox"/> jaundice, <input type="checkbox"/> shingles.	
				5T	Liver, solar plexus, circulation (general).	<input type="checkbox"/> liver conditions, <input type="checkbox"/> fevers, <input type="checkbox"/> blood pressure problems, <input type="checkbox"/> poor circulation, <input type="checkbox"/> arthritis.	
				6T	Stomach.	<input type="checkbox"/> stomach troubles or nervous stomach, <input type="checkbox"/> indigestion, <input type="checkbox"/> heartburn, <input type="checkbox"/> dyspepsia.	
				7T	Pancreas, duodenum.	<input type="checkbox"/> ulcers, <input type="checkbox"/> gastritis.	
				8T	Spleen.	<input type="checkbox"/> lowered resistance.	
				9T	Adrenal and supra-renal glands.	<input type="checkbox"/> allergies, <input type="checkbox"/> hives.	
				10T	Kidneys.	LOW BACK	<input type="checkbox"/> kidney troubles, <input type="checkbox"/> hardening of the arteries, <input type="checkbox"/> chronic tiredness, <input type="checkbox"/> nephritis, <input type="checkbox"/> pyelitis.
				11T	Kidneys, ureters.		<input type="checkbox"/> skin conditions such as acne, <input type="checkbox"/> pimples, <input type="checkbox"/> eczema, <input type="checkbox"/> or boils.
		LUMBAR SPINE	SACRUM	12T	Small intestines, lymph circulation.	<input type="checkbox"/> rheumatism, <input type="checkbox"/> gas pains, <input type="checkbox"/> certain types of sterility.	
1L	Large intestines, inguinal rings.			<input type="checkbox"/> constipation, <input type="checkbox"/> colitis, <input type="checkbox"/> dysentery, <input type="checkbox"/> diarrhea, <input type="checkbox"/> some ruptures or hernias.			
2L	Appendix, abdomen, upper leg.			<input type="checkbox"/> cramps, <input type="checkbox"/> difficult breathing, <input type="checkbox"/> minor varicose veins.			
3L	Sex organs, uterus, bladder, knees.			<input type="checkbox"/> bladder troubles, <input type="checkbox"/> menstrual troubles such as painful or irregular periods, <input type="checkbox"/> miscarriages, <input type="checkbox"/> bed wetting, <input type="checkbox"/> impotency, <input type="checkbox"/> change of life symptoms, <input type="checkbox"/> many knee pains.			
4L	Prostate gland, muscles of the lower back, sciatic nerve.			<input type="checkbox"/> sciatica, <input type="checkbox"/> lumbago, <input type="checkbox"/> difficult, painful, or too frequent urination, <input type="checkbox"/> backaches.			
SACRUM	COCCYX	5L	Lower legs, ankles, feet.	<input type="checkbox"/> poor circulation in the legs, <input type="checkbox"/> swollen ankles, weak ankles and arches, <input type="checkbox"/> cold feet, <input type="checkbox"/> weakness in the legs, <input type="checkbox"/> leg cramps.			
		SACRUM	Hip bones, buttocks.	PELVIS	<input type="checkbox"/> sacro-iliac conditions, <input type="checkbox"/> spinal curvatures.		
		COCCYX	Rectum, anus.		<input type="checkbox"/> hemorrhoids (piles), <input type="checkbox"/> pruritis (itching), <input type="checkbox"/> pain at end of spine on sitting.		

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.



TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Lake Houston Wellness for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Lake Houston Wellness Center LLC to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and 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, disk 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 upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.



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I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, 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 conditions(s) for which I seek treatment.

Signature _____ Date _____ (If under age 18) Parent's signature _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature _____

Date _____

Consent to x-ray:

I hereby grant Lake Houston Wellness Center, L.L.C. permission to perform an x-ray evaluation if needed of _____. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Signature (parent if minor) _____ Date _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature _____

Date _____

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature _____ Date _____

(If under age 18) Parent's signature

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and



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- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Texas Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Texas Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form, you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: _____

Date: _____

If not signed by the patient, please indicate relationship.

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____
