CY-FAIR HEALTHCARE ASSOCIATES
Cy-Fair Chiropractic Associates, PC/Cy-Fair Pain Intervention, PLLC
11514 Fallbrook Dr.
Houston, TX 77065
P. 281-955-9946 F. 281-469-0439
CHIROPRACTIC * PHYSICAL THERAPY * MEDICAL

Welcome to our clinic. Our clinic is a comprehensive facility offering a varity of healthcare services, including, chiropractic, medical, wellness, physical therapy, pain management, acupuncture, massage, exercise rehabilitation and medical weight loss. Our services, aslo include diagnostic and physical orthopedic and neurological examaination procedures, digital diagnostic X-ray and digital diagnostic Fluroscopic X-ray, We also, provide We also, provide laboratory testing, hormonal testing, trigger point injections and peripheral and spinal steroid injections.

What To Expect On Day One:

On day one, you will complete this patient history and clinic consent forms, if you have not already done so. Typically one of the doctor's assistants will take your vitals and prepare your chart for an initial consultation with our family nurse practitioner who will assess for trigger point injections and prescription medication, if needed and prove to be helpful, to treat acute episodes of muscle spasms and pain. This is followed by an orthopedic and neurological physical therapy examination with one of our clinic doctors. Please note that all services are ultimately the patient's responsibility. If you are not aware of your insurance benefits and have not meet with one of our case managers please ask to do so.

On site diagnostic services include Computerized digital X-ray (The golden standard for spine and joint diagnosis), Video Fluoroscopy, a type of X-ray (This is helpful to ensure the safe and proper position of the injection for spine and peripheral joint injections), Diagnostic Ultrasound (This is helpful for trigger point and peripheral joint injections), neurodiagnostic EMG/NCV nerve test (This is helpful to diagnosis nerve injury), as well as, laboratory Blood testing for medical weight loss and hormonal therapy.

Upon completion of the physical examination, a verbal explanation will be given to you with regards to your presenting complaints. Based on our initial impression, the possible cause of your condition will be explained to you. A plan of immediate care will follow if your complaints are acute. This could consist of trigger point injections, prescription medications and physical therapy in order to start reducing muscle spasms, pain and inflammation on day one. Treatment will only start after the risks and benefits are explained to you and you understand and wish to proceed. If presenting complaints are more of a chronic condition then treatment may not begin on day one. In this situation a second visit will be scheduled for a report of findings.

What To Expect On Day Two:

During the report of findings (ROF), we will explain how your problems may have occurred, and what is, in all likelihood, causing your pain and/or problems. These findings would then determine your treatment plan. We will explain to you the benefit of each type of treatment that is indicated, and will provide to you a recommended plan of care, if necessary. WE DO REQUEST THAT SPOUSES AND/OR GUARDIANS ATTEND THIS ROF as we provide, in most cases, home care, requiring support and assistance. Upon acceptance of your case and your consent to proceed with treatment, financial arrangements are then made with you and appointments are scheduled.

Patient Case History

Please complete this questionnaire. Your answers will help us determine if we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ E-Mail: _____

City: _____ State: _____ Zip Code: _____

☐Home Phone: _____ ☐ Work Phone: _____ ☐ Cell: _____
Indicate preffered method of contact by checking appropriate box.

Marital Status: _____ Home Fax: _____

Date of Birth: _____ Male/Female: _____ No. of Children _____

Your Social Security No. (Required for workman Comp PI Case: _____

Your Employer: _____ Spouses Name: _____

Your Occupation: _____ Spouses Work Number: _____

Spouses Employer: _____

PRESENT COMPLAINTS:

Please describe the principal health problem(s) for which you came to this office: _____

_____

_____

HISTORY OF COMPLAINTS:

List the date or the approximate date the above complaints occurred: _____

Is your condition due to an accident/ injury, I.e., Auto, Work or Sports accident/injury? ☐ Yes ☐ No

If yes, please explain: _____

Date of accident: _____ Time _____ AM/PM Location _____

If Auto, was a police report made or at work was your employer notified? ☐ Yes ☐ No

If Auto do you have an Attorney advising you on this case? ☐ Yes ☐ No

If yes, list name, address and phone number of your attorney. _____

Have you lost any days of work due to this accident/injury? ☐ Yes ☐ No If so, list dates: _____

Have you seen any other doctors for these complaints? ☐ Yes ☐ No

If yes, list the doctor names and telephone numbers. _____

PAST MEDICAL HISTORY:

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If Yes When? _____

Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, give date of last treatment: _____

Are you presently under the care of any other Doctor(s) ☐ Yes ☐ No

If yes, explain: _____

Are you currently under medication? ☐ Yes ☐ No

If so, what kind and for what condition? _____

List approximate date(s) of any surgery and/or unusual diseases/illnesses: _____

FAMILY HISTORY: _____

_____

SOCIAL HISTORY: _____

☐ **Drink** ☐ Smoke ☐ Drugs

Please check the appropriate box for any of the following symptoms.

N-NONE O - OCCASIONAL F - FREQUENT C - CONSTANT

GENERAL

N	O	F	C	
☐	☐	☐	☐	Allergy
☐	☐	☐	☐	Chills
☐	☐	☐	☐	Convulsions
☐	☐	☐	☐	Dizziness
☐	☐	☐	☐	Fainting
☐	☐	☐	☐	Fatigue
☐	☐	☐	☐	Fever
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Loss of sleep
☐	☐	☐	☐	Loss of weight
☐	☐	☐	☐	Nervousness/depression
☐	☐	☐	☐	Neuralgia
☐	☐	☐	☐	Numbness
☐	☐	☐	☐	Sweats
☐	☐	☐	☐	Tremors

MUSCLE & JOINT

☐	☐	☐	☐	Arthritis
☐	☐	☐	☐	Bursitis
☐	☐	☐	☐	Foot trouble
☐	☐	☐	☐	Hernia
☐	☐	☐	☐	Low back pain
☐	☐	☐	☐	Lumbago
☐	☐	☐	☐	Neck pain or stiffness
☐	☐	☐	☐	Pain between shoulders
				Pain or numbness in:
☐	☐	☐	☐	Shoulders
☐	☐	☐	☐	Arms
☐	☐	☐	☐	Elbows
☐	☐	☐	☐	Hands
☐	☐	☐	☐	Hips

N	O	F	C	
☐	☐	☐	☐	Legs
☐	☐	☐	☐	Knees
☐	☐	☐	☐	Feet
☐	☐	☐	☐	Painful tail bone
☐	☐	☐	☐	Poor posture
☐	☐	☐	☐	Sciatica
☐	☐	☐	☐	Spinal curvature
☐	☐	☐	☐	Swollen joints

GASTRO-INTESTINAL

☐	☐	☐	☐	Belching or gas
☐	☐	☐	☐	Colitis
☐	☐	☐	☐	Colon trouble
☐	☐	☐	☐	Constipation
☐	☐	☐	☐	Diarrhea
☐	☐	☐	☐	Difficult digestion
☐	☐	☐	☐	Distension of abdomen
☐	☐	☐	☐	Excessive hunger
☐	☐	☐	☐	Gall bladder trouble
☐	☐	☐	☐	Hemorrhoids
☐	☐	☐	☐	Intestinal worms
☐	☐	☐	☐	Jaundice
☐	☐	☐	☐	Liver trouble
☐	☐	☐	☐	Nausea
☐	☐	☐	☐	Pain over stomach
☐	☐	☐	☐	Poor appetite
☐	☐	☐	☐	Vomiting
☐	☐	☐	☐	Vomiting of blood

CARDIO-VASCULAR

☐	☐	☐	☐	Hardening of arteries
☐	☐	☐	☐	High blood pressure
☐	☐	☐	☐	Low blood pressure

N	O	F	C	
☐	☐	☐	☐	Pain over heart
☐	☐	☐	☐	Poor circulation
☐	☐	☐	☐	Rapid heart beat
☐	☐	☐	☐	Slow heart beat
☐	☐	☐	☐	Swelling of ankles

RESPIRATORY

☐	☐	☐	☐	Chest pain
☐	☐	☐	☐	Chronic cough
☐	☐	☐	☐	Difficult breathing
☐	☐	☐	☐	Spitting up blood
☐	☐	☐	☐	Spitting up phlegm
☐	☐	☐	☐	Wheezing

GENITO-URINARY

☐	☐	☐	☐	Bed-wetting
☐	☐	☐	☐	Blood in urine
☐	☐	☐	☐	Frequent urination
☐	☐	☐	☐	Inability to control kidneys
☐	☐	☐	☐	Kidney infection/stones
☐	☐	☐	☐	Painful urination
☐	☐	☐	☐	Prostate trouble
☐	☐	☐	☐	Pus in urine

FOR WOMEN ONLY

☐	☐	☐	☐	Congested breasts
☐	☐	☐	☐	Cramps or backache
☐	☐	☐	☐	Excessive menstrual flow
☐	☐	☐	☐	Hot flashes
☐	☐	☐	☐	Irregular cycle
☐	☐	☐	☐	Menopausal symptoms
☐	☐	☐	☐	Painful menstruation
☐	☐	☐	☐	Vaginal discharge

☐Yes ☐No Are you pregnant?

COMMENTS: _____

_____

_____

_____

FINANCIAL AND PAYMENT POLICY

Payment is expected at the time services are rendered, unless other arrangements have been made in advance. Any amount owed by the patient, not paid by the insurance company is due immediately. Insurance assignments are accepted on most Health care policies, Worker's Compensation, personal injury auto policies, and medicare policies.

If you are here due to injuries sustained in an automobile accident, and if you do not have Personal Injury protection. Med pay and/or Group Insurance to pay for treatments rendered, then a "good faith" payment plan will be established for third party cases. Payment of account is due 60 days after billing has been provided to carrier.

On all assignments accepted by this facility, you must sign the "Assignment of Proceeds Form" in order for the carrier to pay us directly for services rendered.

Insurance coverage is verified as soon as possible by this clinic. As an in network and/or out of network provider, we will make every attempt to determine what the patients out of pocket expenses are, however, the exact out of pocket expenses will not be known until we receive the explanation of benefits (EOB) from the insurance carrier. If there are additional out of pocket expenses, a statement will be mailed to you, and Payment is expected to Be Received within 30 days. If Payment is not received within 30 days A Late Fee will be charged on subsequent statements. If there is an overpayment, a credit or refund will be issued. If your claims are denied and/or not paid within 60 days, you are responsible for the full amount of our bill.

This office will release copies of original records and/or x-rays upon written request from the patient along with a payment for duplicating, postage and handling of records.

"I understand that in agreeing to provide health care to me as a workers' compensation patient, you have relied on my representations of the time, date, and circumstances of the incident which caused my injuries and my prior medical history, and that my injury was related to my employment. I understand that (1) if I have misrepresented any these facts to you and my claim is ultimately denied, you may hold me personally liable for the costs of your treatment to me; OR (2) in the event that my claim for workers' compensation is determined by final adjudication to be noncommunicable, I and/or my private health care insurance my be liable to you for all or part of the costs of my treatment."

If you understand the above policies and wish to be evaluated and treated by the doctors and staff at this facility, please print and sign your name below, indicating that the risk and benefits have been explained to you and you understand and wish to proceed with treatment and/or injections ordered by the providers at this facility.

Patient's Name Print: _____ Signature: _____

Parent or Legal Guardian, If Patient Is Under 18 Years Of Age.

Print Name: _____ Signature: _____

Relationship To Patient: _____ Date: _____

For insurance claims if you are not the policy holder please print the name and DOB of the policy holder:

Print Name: _____ DOB: _____

Required:

In case of emergency, please notify:

_____

(Friend or relative not living with you)

Relationship: _____ Phone Number: _____

Address: _____