

NAME: _____ DATE: ____/____/____

ADDRESS: _____ CITY/ZIP _____

EMAIL: _____ SOCIAL SECURITY #: ____ - ____ - ____

HOME PHONE: (____) ____ - ____ CELL PHONE (____) ____ - ____ AGE: _____

DATE OF BIRTH: ____/____/____ SEX: M F Marital Status: Single__ Married__ Divorced__ Widowed__

EMPLOYER INFORMATION

EMPLOYER NAME: _____ POSITION: _____

ADDRESS: (Street) _____

(City): _____ (State): _____ (Zip): _____ PHONE: (____) ____ - ____

SPOUSE INFORMATION / EMERGENCY CONTACT

NAME: _____ WORK PHONE: (____) ____ - ____

EMPLOYER: _____ POSITION: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: (____) ____ - ____

INSURANCE INFORMATION

INSURANCE NAME: _____ INSURED NAME: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

POLICY # _____ GROUP# _____ CLAIM# _____

EFFECTIVE DATE: ____/____/____

HOW DID YOU HEAR ABOUT US? _____

SIGNATURE: _____

DATE: ____/____/____

Dynamic Health & Wellness

2107 West Davis, Ste G Conroe, TX 77304 (936)756-1651 Fax (936)756-1658

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have been offered this office's Notice of Privacy Practices, which explains how my private health information (PHI) will be used and disclosed. I understand that I am entitled to receive a copy of this document at any time.

Name of Patient

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

HEALTH DISCLOSURE INFORMATION

I, _____, hereby authorize the staff of *Dynamic Health & Wellness* to disclose information to the following person(s) about my procedures, as well as any other information concerning my health. I also authorize the following person(s) to receive information concerning my financial statement.

Name	Relationship	Initial
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

PLEASE NOTE:

There will be times this office will call and leave messages regarding appointments and/or procedures.

This will be effective until I, _____, put in writing that I withdraw the above listed person(s).

Signature

Date

Consent to Services

1. I, _____, authorize the performance upon my person the following procedure(s):

<input type="checkbox"/> Manipulation	<input type="checkbox"/> X-Rays	<input type="checkbox"/> Blood Work
<input type="checkbox"/> Physical Medicine	<input type="checkbox"/> Examination	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Other _____		

2. In addition, I understand that other examination and treatment procedures may be necessary throughout the course of my admission and I understand that I will be so informed of the intent to perform and risks and benefits of the proposed procedures.

3. The nature and purpose of these procedures, possible alternatives, the risks involved, the possible consequences and the possibility of complication have been sufficiently explained to me by clinic physicians and/or their designees.

4. I understand that there are charges for these procedures and that the finance department upon my request will explain them to me.

Date: ____/____/____
Month Day Year

Signed: _____

Witness: _____

Relationship: _____

Assignment of Insurance Benefits

I, the undersigned claimant, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes ***Dynamic Health & Wellness*** to submit claims for benefits, for services rendered or for services to be rendered without obtaining signature on each and every claim to be submitted for me and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I hereby authorize MY INSURANCE COMPANY: _____ to pay and hereby assign directly to ***Dynamic Health & Wellness*** all benefits, if any, otherwise payable to me for services as described on the attached forms, and I also agree to pay co-payments and/or deductibles on a weekly basis.

I understand that I am financially responsible for all charges incurred and that any insurance benefits, when received by and paid to ***Dynamic Health & Wellness*** will be credited to my account in accordance with the above assignment.

I further acknowledge that verification of benefits is not a guarantee of payment from my insurance company.

Claimant Signature: _____

Date: ____/____/____

Past Medical History

Name: _____

Date: _____

Social History

Do you currently use or have used tobacco? Yes No If yes, which types? _____

Do you use street drugs? Yes No Type: _____ Quit: _____

Do you drink alcohol? Yes No Number of Drinks/week _____

Medical History: Please check all previous or current illnesses

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision/Hearing |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Bone or skeletal problems |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> PMS/PMDD |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Kidney/Urine Problems | <input type="checkbox"/> Headaches / Migraines |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Depression/Anxiety |

Have you treated/managed your current illness with nutrition and/or supplements? Yes No

If no, would you like to set up an appointment with Dr. Faysal for a nutritional consultation? Yes No

Please provide a description of your past illnesses for the boxes you checked above (write on the back if necessary)

Past Surgical History: (include the type of surgery and date)

Cancer History

Have you been diagnosed with cancer? Yes No

Diagnosis: _____ Age: _____

Treatment: _____

At what institution was this cancer treated? _____

Family History Living Age (or age at death) List serious illnesses

Mother (Age) _____

Father (Age) _____

Siblings (Age) _____

Medication: (current and in the past 3 months)

Supplements: (current and in the past 3 months)

WHERE is your pain today? (Please check all that applies)

- Neck
- Shoulder
- OTHER _____
- Upper Back
- Lower Back
- Hip
- Knee
- Ankle
- Headache

WHEN did this pain begin? ____/____/____; **Has your pain:** progressively worsened / gotten better / same?

Have you had a history of this pain or any similar pain? Yes No

If YES, explain. _____

WHAT were you doing when this pain began? (Please explain)

Have you seen another doctor(s) for your current pain? Yes No

If YES, who? _____

Are you currently taking medication(s) for this pain? Yes No

If YES, list. _____

Have you had an X-RAY or MRI? Yes No

- X-ray Date: _____
- MRI Date: _____
- Other Date: _____

What makes this pain WORSE? (Please be specific)

Bending/Stooping Twisting Turning Lifting Sitting Cough/Sneeze Lying Down Standing Walking

OTHER _____

What makes this pain BETTER? (Please be specific)

Ice Heat Rest Laying Down Medication Sitting Standing Walking Sleeping

OTHER _____

Are you having any pain in your arms and/or legs? (Please explain)

DESCRIBE your pain. (Please circle & explain)

DULL/ACHY SHARP THROBBING STABBING NUMB/TINGLE TIGHT OTHER:

Explain: _____

RATE your pain? (Please circle 0-10)

0 1 2 3 4 5 6 7 8 9 10
 NO PAIN SOME PAIN PAIN AFFECTS LIVING EMERGENCY ROOM

How often do you feel this pain? (Please circle percentage)

0 10 20 30 40 50 60 70 80 90 100

When is the pain worse? (Please check)

- Morning
- Daytime
- Nighttime
- Sleep
- Progressively worse as the day goes by

Do you exercise? Yes No

If YES, how often and how much?
 _____ days/week _____ minutes/day

Do you smoke? Yes No

If YES, how much? _____ pack(s)/day