Texas Natural Healthcare

Where Science & Nature Meet

INFORMATION / APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions.

Today's Date _____ **E-Mail Address** _____

First Name _____ **Last Name** _____

Address: _____ **City** _____ **State** _____

Driver's License # _____

Primary Contact Ph# _____ Mine Spouses Work Other _____

Secondary Contact Ph# _____ Mine Spouses Work Other _____

Emergency Contact Ph# _____ Mine Spouses Work Other _____

Age _____ Birth date _____ Marital Status: S M W D No. of Children _____

Please check one payment type: ☐ Cash ☐ Master Card/Visa ☐ American Express

Your Employer _____Occupation _____ Years _____

Employer Address _____

City _____ State _____ Zip _____

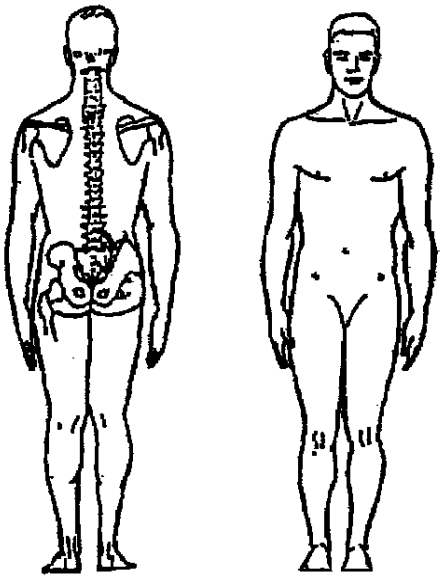
Your Social Security # _____

Name of Spouse or Parent _____ Their Birthdate _____

Spouse Employed By _____ Occupation _____Years ____

Employer Address _____ City _____

State _____ Zip _____ Spouse Social Security # _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram.

Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain.

For example; dull, sharp, consistent, off & on, when standing, when sitting, etc……

MAJOR COMPLAINTS:
Please list any condition you are being treated for or are experiencing.

***YOUR MAJOR REASON FOR SEEING THE DOCTOR:**

_____

_____

_____

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IMPORTANT: The information requested in **this form is** of **vital importance** in determining the care and correction of your health problem.

CONDITIONS Check conditions you have or have had in the past.

- ☐ Aids
- ☐ Alcoholism / Addiction
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ AutoImmune diseases
- ☐ Bleedingdisorders
- ☐ Breast fibrocysts
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chickenpox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibroids
- ☐ Fractures
- ☐ G.E.R.D.
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis AB or C
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Prosthesis
- ☐ Psychiatric care
- ☐ Rheumatic Fever
- ☐ Rheumatoid arthritis
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, growths
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease
- ☐ Whooping cough
- ☐ Other _____
- ☐ Other _____

Have you ever been in an auto accident(s)? Yes _____ No _____

Date of accident? _____ Date of accident? _____

Date of accident? _____ Date of accident? _____

Other types of accidents? Work/On Job _____ At Home _____ Other _____

Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

Describe Your Accident History:

_____

_____

_____

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FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Siblings		Children		
	Age	Age	Age	Age	Age	Age	Age	Age
ADHD								
Allergies								
Arthritis								
Asthma								
Autism								
Back Trouble								
Bed Wetting								
Bursitis								
Cancer								
Chest Pain								
Colic								
Constipation								
Crohn Disease								
Depression								
Diabetes								
Diarrhea								
Disc Problems								
Down Syndrome								
Ear Infection								
Emotion Issues								
Emphysema								
Epilepsy								
Headaches								
Migraines								
Heartburn								
Heart Trouble								
High Blood Press								
IBS								
Indigestion								
Infertility								
Insomnia								
Kidney Trouble								
Neck Pain								
Neuritis								
Nervousness								
Pinched Nerve								
Scoliosis								
Sinus Trouble								
Other								
Thank you! PLEASE ADD ADDITIONAL INFORMATION AS NEEDED								

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I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred.

I understand and agree that I am personally responsible for payment of any and all services.

I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Or Parent's Signature _____ Date _____

Insurance: **THIS OFFICE DOES NOT ACCEPT INSURANCE PAYMENTS**

You may submit your paid services for reimbursement to your insurance company.

Texas Natural Healthcare will provide you with the following information on a "superbill"

- Date of service
- Type of service and associated CPT codes
- Chiropractic related diagnostic codes

CONSENT FOR CARE FORM BELOW

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INFORMED CONSENT TO CHIROPRACTIC CARE

In our office we use standard diagnostic procedures to document and verify injuries/illnesses. In conjunction with our standard and conventional evaluation procedures, occasionally we may find it necessary to utilize experimental procedures (which are safe and non-invasive).
By signing below you consent to the performance of these procedures, as we may consider them necessary or advisable in the course of your care. If you have any questions or concerns please feel free to consult with your doctor.

THE PROBABILITY OF SOME RISK OCCURING

- Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history as well as during the examination and if indicated, referral for diagnostic imaging.

- The occurrence of strokes has been the subject of tremendous disagreement within as well as outside of the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. Other complications are also generally described as “rare.”

I have had the opportunity to discuss with the doctor named below the nature, purpose and risk of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. **I understand that the results are not guaranteed.**

I have read the above explanation of the chiropractic adjustments and related treatments. By signing below I state that I have weighed the risk involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

NAME AND ADDRESS OF OFFICE
Texas Natural Healthcare
9500 Ray White Road
Fort Worth, Tx 76244

NAME OF TREATING DOCTOR

Steve L. Kellenberger, B.S., D.C.

_____
PRINTED NAME OF PATIENT

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PATIENT’S REPRESENTATIVE DATE

_____ _____
WITNESS TO PATIENT’S SIGNATURE DATE