NEW PATIENT INFORMATION

OPTIMUM SPINE

STEP ONE: (Day One)
New patients will complete this detailed personal information form.

STEP TWO: (Day One)
A consultation with Doctor Nannis to discuss your specific health problem and to determine what may be the cause.

STEP THREE: (Day One)
A comprehensive examination and evaluation will be performed. This includes those tests necessary to determine the precise cause of your condition.

STEP FOUR: (Day One)
Doctor Nannis will advise you if additional laboratory tests or other tests including x-rays are needed.

STEP FIVE: (Day One)
First aid treatment will be provided if warranted, and you will be advised of any home directions necessary to protect your health.

STEP SIX: (Day Two)
A Report of Findings will be presented, at which time the cause of your problem will be discussed. You will be given a through explanation of how chiropractic works and how best results can be obtained. You will also be advised how our office procedure works.

STEP SEVEN: (Day Two)
The first adjustment will be performed. This completes the diagnostic procedures; we will monitor response overnight.

STEP EIGHT: (Day Two)
An estimate of the future care that is needed will be given and upon your acceptance, a care plan will be established and followed until you obtain maximum correction for your body.

STEP NINE: (Within first two weeks)
A spinal care class explaining the causes of disease, mechanisms of healing, and supportive procedures you should perform between visits will be held. Guests are encouraged to attend this informative class.

OPTIMUM HEALTH

EQUALS

NANNIS CHIROPRACTIC FAMILY HEALTH CENTER

PATIENT INFORMATION FORM

[ ] Female
[ ] Male

Name: _____ Nick Name: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____ Date of Birth: ___/___/___ Age: _____

Social Security #: _____ Employer: _____ Occupation: _____

Driver License #: _____ State: _____ Referred by: _____

Marital Status: (check) [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Spouse Name: _____ Spouse Social Security #: _____

Spouse Date of Birth _____ Spouse Employer: _____

Name and age of children: _____

Name of Nearest Relative Not Living With You: _____ Phone: _____

(If Under 18) Name of Parent or Guardian: _____

Parent of Guardian Home Phone: _____ Work Phone: _____

Chief Complaint:

Please describe your current condition. (How do you feel? Where does it hurt)

_____

_____

Which of the following body signals have you experienced in the last 6 months? (check all that apply)

[ ] Memory Loss	[ ] Pain moving into Legs	[ ] Pain in Jaw
[ ] Headache	[ ] Head seems too Heavy	[ ] Clicking and Popping in Jaw
[ ] Neck Pain	[ ] Pins and Needles in Arm	[ ] Dizziness
[ ] Neck Stiffness	[ ] Pins and Needles in Leg	[ ] Loss of Balance
[ ] Upper Back Pain	[ ] Numbness in Fingers	[ ] Nausea
[ ] Middle Back Pain	[ ] Numbness in Toes	[ ] Constipation
[ ] Lower Back Pain	[ ] Tingle in Fingers	[ ] Diarrhea
[ ] Nervousness	[ ] Tingle in Toes	[ ] Cold Feet
[ ] Bruises	[ ] Shortness of Breath	[ ] Cold Hands
[ ] Cuts	[ ] Fatigue (tired)	[ ] Upset Stomach
[ ] Nightmares	[ ] Depression	[ ] Cold Sweats
[ ] Irritability, Tension	[ ] Light Bothers Eyes	[ ] Fever
[ ] Chest Pains	[ ] Flushed Face	[ ] Blood in Urine
[ ] Pain moving into Arms	[ ] Broken Bones	[ ] Nose Bleeds
[ ] Sleeping Problems	[ ] Allergies	[ ] Vomiting

Any NOT listed above: _____

Date condition began: _________ or Date of accident _________ Time of _____ am pm

What makes you feel better?

What makes you feel worse?

Describe your accident: _____

Have you missed work because of your accident? [ ] Yes [ ] No If yes when? _____
Are your WORK activities restricted ? [ ] Yes [ ] No If yes explain: _____
Are your RECREATION activities restricted [ ] Yes [ ] No If yes explain: _____

Past Medical History

Have you seen another doctor for this condition [ ] yes [ ] no If yes who? _____
Previous Doctor of Chiropractic care? Dr._____ Phone: _____When was your last visit?_____

Who is your family physician? Dr. _____Phone:_____ When was your last visit? _____

What non-prescription drugs are you taking? _____

What prescription drugs are you taking? _____

What side effects do these drugs have? _____
Have you had any of the following diseases?
[ ] Anemia [ ] Heart Disease [ ] Arthritis [ ] Epilepsy [ ] Mental Disorder [ ] Liver disease
[ ] Polio [ ] Tuberculosis [ ] Diabetes [ ] Cancer [ ] AIDS/HIV [ ] Kidney disease
Other: _____
Have you ever been hospitalized? [ ] yes [ ] no
If yes explain: _____

Have you ever broken any bones? [ ] yes [ ] no
If yes explain:_____

Do you have any congenital and or birth conditions [ ] yes [ ] no
If yes explain: _____

Family History

	Back	Heart	Stroke	Cancer	Diabetes	High blood Pressure	Other
Mother	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Father	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Sisters # ___	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Brother # ___	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	_____

Lifestyle Have you ever:

[ ] Joined a Health Club
[ ] Bought Bottled Water
[ ] Used a Water Filter
[ ] Performed Meditation
[ ] Used Acupuncture
[ ] Used Homeopathic Remedies
[ ] Used Supplements
[ ] Bought Organic Foods

How often do you

Exercise:	Daily	3X/wk	1X/wk	2X/mt	1X/mt Never
Drink Alcohol:	Daily	3X/wk	1X/wk	2X/mt	1X/mt Never
Smoke:	Daily	3X/wk	1X/wk	2X/mt	1X/mt Never
Work on a computer:	Daily	3X/wk	1X/wk	2X/mt	1X/mt Never
Sit at a desk:	Daily	3X/wk	1X/wk	2X/mt	1X/mt Never
Work on the phone:	Daily	3X/wk	1X/wk	2X/mt	1X/mt Never

How old is your bed's mattress? _____

CONSENT FOR TREATMENT/TERMS OF ACCEPTANCE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Ray L. Nannis 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 Dr. Ray L. Nannis, including those working at the clinic or office located at 1600 N. Plano Road, Suite 1000, Richardson, Texas, or any other clinic, whether signatories to this form or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. 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

When a patient seeks chiropractic health care and is accepted as a patient for such care, it is essential for both the patient and the doctor to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. 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 of correction is by specific adjustment 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 vertebrae 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 any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the 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. Our only method is specific adjusting to correct vertebral subluxations.

I understand that all records and x-rays taken in this office are the property of Nannis Chiropractic Family Health Center.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient signature_____ Date_____

Guardian/Representative signature_____

Office signature_____ Date_____

PREGNANCY AFFIRMATION

I affirm, to the best of my knowledge that I am not currently pregnant. Should this condition change I will notify Dr. Nannis and/or his staff as soon as possible.

Date of Last Menstrual Period_____

Patient Signature_____ Date_____

Guardian/Representative signature_____

Nannis Chiropractic Family Health Center

Collins Court Suite 1000 – 1600 North Plano Road, Richardson, Texas 75081 – (972) 671-2225

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

With my signature below, I give consent for the Dr. Ray L. Nannis, PC (the Practice) to use and or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations.

I have reviewed the Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the address/phone number/fax number/e-mail address listed on my "New Patient Information Sheet except:

The Practice may communicate confidential information about me to the following individual(s):

_____

_____ _____

Name of Individual (Printed) Signature of individual

_____ _____

Signature of Legal Representative* Relationship

Witness: _____

*Attorney-In-Fact, Guardian, Parent if a minor

PLEASE CHECK OFF THE FOLLOWING THAT APPLY TO YOU:

Digestive Track
__nausea & vomiting
__diarrhea
__constipation
__bloated feeling
__stomach pains or cramps
__heart burn
__blood and/or mucous in stools

Ears
__itchy ears
__ear aches/ear infections
__drainage from ear
__ringing in ears
__hearing loss
__reddening of ears

Emotions
__mood swings
__anxiety/fear/nervousness
__anger/irritability/aggressiveness
__argumentative
__frustrated/cries easily
__Depression **S**

Eyes
__watery or itchy eyes
__red/swollen/itchy eyelids
__bags or dark circles under eyes
__blurred or tunnel vision

Head
__headaches
__faintness
__dizziness
__insomnia/sleep disorder
__facial flushing

Date_____

Patient Name_____

Heart
__Irregular/Skipped Heartbeat **S**
__Rapid/Pounding Heartbeat **S**
__Chest Pain **S**

Joints & Muscles
__pains/aches in joints
__arthritis/osteoarthritis
__stiffness/limited movement
__pain/aches in muscles
__feeling weak/tired
__swollen/tender joints
__growing pains in legs
__Psoriatic/Gouty Arthritis **S**
__Rheumatoid Arthritis **S**

Lungs
__chest congestion
__bronchitis
__shortness of breath
__difficulty breathing
__persistent cough
__wheezing

Mind
__poor memory
__difficulty completing projects
__difficulty with mathematics
__underachiever
__poor/short attention span
__confusion
__easily distracted
__difficulty making decisions
__mild learning Disabilities

Mouth & Throat Thrush
__chronic coughing
__gagging/clearing throat often
__sore throat/hoarse voice/voice loss
__swollen/discolored tongue/lips
__canker sores
__itching on roof of mouth

Nose
__stuffy nose
__chronically red/inflamed nose
__sinus problems
__hay fever
__sneezing attacks
__excessive mucous formation

Skin
__acne
__itching
__hives/rash/dry skin
__hair loss
__flushing/hot flashes

Weight
__binge eating/drinking
__craving certain foods
__excessive weight
__compulsive eating
__water retention

General
__frequent illness
__frequent/urgent urination
__genital itch/discharge
__anal itching

Genitourinary
__kidney problems
__urinary tract
__bladder
__yeast infections

Other Conditions
__Autism **S**
__A.D.H.D. **S**
__A.D.D. **S**
__Psoriasis **S**
__Eczema **S**
__Auto Immune Disorder **S**
__Chronic Fatigue **S**
__Multiple Chemical Sensitivities **S**
__Asthma **S**
__Congestive Heart Failure **S**
__Severe Diabetic **S**
__Severe Depression **S**
__Obsessive Compulsive Disorder **S**