PLEASE COMPLETE THE ATTACHED FORMS AND BRING THEM WITH YOU (ALONG WITH THIS COVER SHEET) TO OUR OFFICE. IF YOU ARE UNABLE TO COMPLETE THESE FORMS PRIOR TO YOUR FIRST VISIT, PLEASE ARRIVE 45-MIN EARLY (60 MIN FOR PERSONAL INJURY CASES) TO LEAVE ENOUGH TIME TO FILL OUT PAPERWORK.

Fort Worth Chiropractic Clinic, PLLC

dba My West Fort Worth Chiropractor ("FWCC")

2920 Oak Park Circle, Suite 101, Fort Worth, TX 76109

(817) 924-7243 |
Support@MyWestFortWorthChiropractor.com

OFFICE USE ONLY: *By Initialing below, I certify that I have reviewed the attached medical forms (including without limit Pre-Day-1-Medical-Forms-CORE-FORMS, Modified-Oswestry-Neck-Index-and-FRI, and Informed Consent to Chiropractic Care) populated with specific data and identifying information. I also certify that any hand-written notations added by me were made on the date below.*

Name of Provider: Derek Page, DC Provider's Initials: _____ Date of Initials: _____/_____/_____

"New Patient Information Forms"

Patient's Full Name: _____ Today's Date: ____/____/_____

Social Security Number: _____ Birth Date: ____/____/_____ Age:_____ Gender: __ F __ M __ O

Marital Status: __Married __Separated __Widowed __Significant Other __Single

CURRENT ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

How did you hear about us / who referred you to us? _____

If Advertisement (TV, Radio, Etc.), Any Promo Code or Name? _____

If Internet Search, What Query Did You Use? _____

==========

If you are under 18 years of age, who are your legal parents or guardian?

__ Father Date of Birth: ____/____/_____ (m) _____ (h) _____

__ Mother Date of Birth: ____/____/_____ (m) _____ (h) _____

__ Legal Guardian / Foster Parent Date of Birth: ____/____/_____ (m) _____ (h) _____

ANY OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street: _____

City: _____ State: _____ Zip: _____

Your Profession: _____ **Your Employer:** _____

Your Work Address: _____ **Your Work Phone:** _____

Student at _____ ☐ **FULL-TIME** ☐ **PART-TIME**

Name of Spouse: _____ Spouse's Date of Birth: ____/____/_____

Spouse's Profession: _____ Spouse's Employer: _____

Spouse's Work Address: _____ Spouse's Work Phone: _____

Spouse is a Student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____

Mobile Phone: _____ **Home Phone:** _____ **Email:** _____

Full Address of Contact Person: _____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/_____

Name of Your Primary Care Clinician: _____ Name of PCC's Practice: _____

City / Town Where Primary Care Clinician's Practice is Located: _____

"New Patient Accident Details Form"

Patient's Full Name: _____ Today's Date: ____/____/_____

Date of Birth: ____/____/_____

Date of Accident: ____/____/_____ Approximate Time of Accident: _____ ___ AM ___ PM

City or town in which accident took place: _____ State: _____

Name of Premises or Specific Location (Road, Intersection, Etc.) Where Accident Took Place: _____

Type of Accident (Check All That Apply): ___ Auto-Related ___ Work-Related ___Slip & Fall

Briefly Describe How the Accident Took Place: _____

Were you taken to the hospital after the accident? ☐ YES ☐ NO By ambulance or private car? _____

Were you taken to the hospital ***immediately*** after the accident? ☐ YES ☐ NO

If not, how much time had elapsed before you went to the hospital? _____

Which hospital were you taken to? _____

Have you been X-rayed since the accident? ☐ YES ☐ NO If so, where? _____

Have you received an MRI since the accident? ☐ YES ☐ NO If so, where? _____

If you suffered extensive injuries as a result of the accident, indicate here: ☐ YES, I suffered extensive injuries as a result of the accident

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained, and names of attorneys who represented you.

Date of Accident: ____/____/_____ Name of Attorney in That Case: _____

Were you a Medicare Patient at the Time? ☐ YES ☐ NO Approximate Date When Case Settled or Was Resolved: ____/____/_____

Date of Accident: ____/____/_____ Name of Attorney in That Case: _____

Were you a Medicare Patient at the Time? ☐ YES ☐ NO Approximate Date When Case Settled or Was Resolved: ____/____/_____

Did a police officer show up at the accident and create a police report? ☐ YES ☐ NO

Do you have a copy of the police report? ☐ YES ☐ NO *(please provide our office with a copy)*

Was a ticket or citation issued by a police officer as a result of the accident? ☐ YES ☐ NO Who received the ticket? _____

AUTOMOBILE ACCIDENTS

Do you have any information, including insurance information, concerning the other parties involved in the accident? ☐ YES ☐ NO

Provide details: _____

Have you been contacted by any adjusters regarding your accident? □ YES □ NO

Adjuster: _____ Insurance Company: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Have you given a statement to this insurance adjuster? □ YES □ NO

Adjuster: _____ Insurance Company: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Have you given a statement to this insurance adjuster? □ YES □ NO

Adjuster: _____ Insurance Company: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Have you given a statement to this insurance adjuster? □ YES □ NO

Did the accident involve a *hit-and-run* driver? ☐ YES ☐ NO Was the Hit-and-Run Vehicle / Driver ever identified? ☐ YES ☐ NO

Provide details: _____

INFO ABOUT THE VEHICLE / DRIVER WHO STRUCK YOU (IF KNOWN)

Driver / Driver's Policy

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Driver: _____

___ The Driver Doesn't Have Insurance According to Driver ___ I Don't Have the Info

Vehicle Owner / Vehicle's Policy (If Not Owned by Patient or Driver)

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Owner of Vehicle: _____

___ The Vehicle Doesn't Have Insurance According to its Occupants ___ I Don't Have the Info

The Vehicle which struck me is/was (select one):

(A) ____ in the business of transporting persons (B) ____ provided by an employer not including "A" (C) ___ neither of these

Examples of (A) include: Commuter vans, taxis, rideshares (e.g., Uber, Lyft), busses, day care shuttles, and school-sponsored shuttles

If (A) or (B) apply, Name of company, organization or employer providing the method of transport:_____

Any Other Info Relating to Any Other Vehicles / Drivers who Struck You? _____

INFO ABOUT YOU … AND RELATED VEHICLES AND PERSONS

I was ___ the Driver ___ a Passenger ___ a Pedestrian Struck by a Vehicle

Ownership of the Vehicle I was occupying: ___ I own / co-own the Vehicle I was occupying ___ I do NOT own / co-own the Vehicle I was occupying

If you own, what is the name of the auto body shop where your car is being repaired? _____

The Vehicle I was occupying is/was (select one):

(A) ____ in the business of transporting persons (B) ____ provided by an employer not including "A" (C) ___ neither of these

Examples of (A) include: Commuter vans, taxis, rideshares (e.g., Uber, Lyft), busses, day care shuttles, and school-sponsored shuttles

If (A) or (B) apply, Name of company, organization or employer providing the method of transport: _____

Patient's Policy

Insurance Co _____ Insurance Agent: _____ Policy # _____

___ I Don't Have Insurance ___ I Don't Have the Info ___ I Would Prefer Not to Provide at This Time

Driver's Policy (If Driver Different Than Patient)

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Driver: _____

___ The Driver Doesn't Have Insurance According to Driver ___ I Don't Have the Info ___ I Would Prefer Not to Provide at This Time

Vehicle's Policy (If Not Owned by Patient or Driver)

Insurance Co _____ Insurance Agent: _____ Policy # _____

Name of Owner of Vehicle: _____

___ The Vehicle Doesn't Have Insurance According to its Occupants ___ I Don't Have the Info ___ I Would Prefer Not to Provide at This Time

Resident-Relative Policy. Do you reside with a family member who owns their own vehicle which may be insured under a different auto policy than your own? – Automobile insurance laws in applicable states require this info (check all that apply)

☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Grandparent ☐ Sister / Brother ☐ Child ☐ None

Insurance Co _____ Insurance Agent: _____ Policy # _____

___ I Do Not Reside with a Family Member Who Owns Their Own Vehicle ___ I Don't Have the Info ___ I Would Prefer Not to Provide

Are you, yourself, licensed to drive? ☐ YES ☐ NO *(please provide our office with a copy)*

Was the car which you were occupying at the time of the accident registered? ☐ YES ☐ NO *(please provide our office with a copy)*

Was there any property damage to any of the vehicles as a result of the accident?

☐ the vehicle which struck me ☐ the vehicle which I was occupying ☐ Neither vehicle was damaged

Describe damage: _____

Do you have pictures? ☐ YES ☐ NO ***(please provide our office with copies)***

Status of Any Settlement – Check all that apply:

☐ YES ☐ NO I have settled the property damage claim to my vehicle

☐ YES ☐ NO I have received a settlement check associated with my BODILY INJURY claim

IF YOU ANSWERED "YES" TO THE ABOVE QUESTION:

☐ YES, I have cashed the check

☐ NO, I have NOT cashed ANY checks associated with my bodily injury claim

☐ YES ☐ NO I have signed a settlement agreement associated with my bodily injury claim *(if YES, please provide our office with a copy)*

Details: _____

Are you currently represented by an attorney? ☐ YES ☐ NO

If NO, do you wish to retain an attorney at this time? ☐ YES ☐ NO Are you currently seeking an attorney? ☐ YES ☐ NO

If YES, answer these:

Name of Attorney (if you are currently represented): _____

Phone or Town of the Attorney: _____

Do you have a Letter of Representation from the attorney? ☐ YES ☐ NO *(please provide our office with a copy)*

Do you have a Letter of Protection signed by the attorney? ☐ YES ☐ NO *(please provide our office with a copy)*

SECTION – CHIEF COMPLAINT

Name of Patient:: _____ Today's Date: ____/____/_____

What is your **CHIEF COMPLAINT**? _____

When did this begin? _____

How did this happen (i.e., car accident, slip or fall, bending and lifting)? _____

_____

_____Have you received treatment for this current episode? ___ YES ___ NO

If YES, what treatment have you had?_____

Have you ever experienced episodes of this in the past? ___ YES ___ NO

If YES, what treatment have you had? _____

_____Severity of pain 0 – 10 (0 is no pain at all and 10 is worst possible pain):

CURRENTLY _____/ 10 Described as: _____

at its **WORST** _____/ 10 Described as: _____

at its **BEST** _____/ 10 Described as: _____

Does the pain **RADIATE** (i.e., down the arm or leg)? ___ YES ___ NO

If YES, please describe: _____

Is your complaint: ___ Improving ___ Getting Worse ___ Staying the Same

What activities make the pain **WORSE** (i.e., sitting, standing, walking. Etc.)? _____

What activities make the pain **BETTER** (i.e., rest, stretching, ice. Etc.)? _____

How often do you experience this pain? ___ Daily ___ 1 – 2x/week ___ 3 or more x/week

Are your symptoms: ___ Constant ___ Half of the Day ___ More than Half ___ Less than Half ___ On and Off ___ Random

Time of day your symptoms are worse: ___ Morning ___ Afternoon ___ Evening ___ Not Applicable

What Activity of Daily Living (ADL) is MOST affected? **(CHOOSE ONLY 1)**

___ Lifting ___ Walking ___ Sitting ___ Driving ___ Standing ___ Sleeping ___ Computer Use

How long are you able to do this before pain starts (i.e. 10 minutes) _____

SECTION – MODIFIED OSWESTRY / NECK INDEX / FUNCTIONAL RATING INDEX

Name of Patient: _____ Today's Date: ____/____/_____ **OFFICE USE ONLY – SCORE:** _____

Please mark which MOST CLOSELY DESCRIBES your condition right now

SECTION 1 – PERSONAL CARE	**SECTION 6 – SOCIAL LIFE / RECREATION / HOUSEHOLD**
□ No pain; no restrictions	□ Can do all activities without pain
□ Pain; no restrictions	□ Can do all activities; but causes pain
□ Pain; need to go slowly	□ Can do most activities; but causes pain
□ Pain; need some assistance	□ Can only do some activities due to pain
□ Pain; need 100% assistance	□ Can only do a few activities due to pain
□ Pain; unable to wash or dress due to pain	□ Cannot do any activities due to pain
SECTION 2 – SLEEPING	**SECTION 7 – HEADACHES**
□ Normal sleep; not disturbed by pain	□ I have no headaches at all
□ Slightly disturbed sleep; less than 1-hour sleepless	□ I have 1 or less headaches per week
□ Mildly disturbed sleep; 1-2 hours sleepless	□ I have 1-2 headaches per week
□ Moderately disturbed sleep; 2-3 hours sleepless	□ I have 3-4 headaches per week
□ Severely disturbed sleep; 3-5 hours sleepless	□ I have 4-5 headaches per week
□ Totally disturbed sleep; 5-7 hours sleepless	□ I have daily headaches
SECTION 3 – SITTING	**SECTION 8 – LIFTING**
□ No pain	□ I can lift as much as I need without pain
□ Pain; does not increase with time	□ I can lift as much as I need; but causes pain
□ Pain; prevents me from sitting more than 1-hour	□ I can only lift moderate weight due to pain
□ Pain, prevents me from sitting more than 30-minutes	□ I can only lift light weight due to pain
□ Pain, prevents me from sitting more than 10-minutes	□ I can only lift weight if it is conveniently positioned
□ Pain, prevents me from sitting at all	□ I cannot lift any weight due to pain
SECTION 4 – STANDING	**SECTION 9 – DRIVING / TRAVEL**
□ No pain	□ No pain
□ Pain; does not increase with time	□ Pain; does not increase with time
□ Pain; prevents me from standing more than 1-hour	□ Pain; prevents me from driving/travel more than 1-hour
□ Pain, prevents me from standing more than 30-minutes	□ Pain, prevents me from driving/travel more than 30-minutes
□ Pain, prevents me from standing more than 10-minutes	□ Pain, prevents me from driving/travel more than 10-minutes
□ Pain, prevents me from standing at all	□ Pain, prevents me from driving/travel at all
SECTION 5 – WALKING	**SECTION 10 – READING / COMPUTER USE**
□ No pain	□ No pain
□ Pain; does not increase with time	□ Pain; does not increase with time
□ Pain; prevents me from walking more than 1-hour	□ Pain; prevents me from reading/computer use more than 1-hour
□ Pain, prevents me from walking more than 30-minutes	□ Pain, prevents me from reading/computer use more than 30-min
□ Pain, prevents me from walking more than 10-minutes	□ Pain, prevents me from reading/computer use more than 10-min
□ Pain, prevents me from walking at all	□ Pain, prevents me from reading/computer use at all

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SECTION – INFORMED CONSENT TO CHIROPRACTIC CARE

Name of Patient: _____

DIRECTIONS: Please read this entire Informed Consent Document prior to signing it. It is important that you understand the information contained in this Document. Please ask questions before you sign if there is anything that is unclear. This Document applies to Care rendered by the Doctors and other Healthcare Staff at our Office.

The nature of the chiropractic adjustment.

The primary treatment used by Doctors of Chiropractic is Spinal Manipulative Therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment.

As part of the analysis, examination, and treatment ("Care"), you are consenting to the following procedures, including but not limited to: Vital Signs, Postural Analysis, Range of Motion Testing, Basic Neurological Testing, Orthopedic Testing, Palpation, Radiographic Studies (including without limit studies performed at the end of your course of Care if deemed necessary or appropriate), Spinal Manipulative Therapy, Massage Therapy, Ultrasound, Hot/Cold Therapy, EMS, Laser Therapy, Spinal Decompression, and others not specifically listed.

The risks inherent in Chiropractic Adjustments.

As with any healthcare procedure, there are certain complications which may arise during Chiropractic Manipulation and Therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including without limit stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Our Doctors will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctors attention it is your responsibility to inform the Doctors.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by Chiropractic Manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR).

I, the below-signed (see "Person 2" below), hereby request and authorize the Care as set forth above to my minor son/daughter/ward. As of this date, I have the legal right to select and authorize healthcare services for the minor child / ward named below. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize Care should be revoked or modified in any way, I will immediately notify the Office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I, have read, or have had read to me, the above explanation of the Chiropractic Manipulative Therapy / Adjustment and related Care. I have discussed it with the Doctor(s) at the Office and have had my questions answered to my satisfaction. By signing this Informed Consent Document below, I state that I have weighed the risks involved in undergoing Care and have decided that it is in my best interest to undergo the Care as recommended or determined in the Doctors' discretion. Having been informed of the risks, I hereby give my consent to such Care.

Patient's Signature: **Patient Full Name –** ____/____/_____ **Date of Signature** ____/____/_____ **Date of Signature at Office**

Person 2's Signature: **Person Full Name –** ____/____/_____ **Date of Signature** ____/____/_____ **Date of Signature at Office**

OFFICE USE ONLY:

By signing below, I attest that I thoroughly discussed this Document and Care with the above-referenced individual(s) prior to the time this Document was signed by such individual(s) at the Office.

Provider's Signature: **Provider's Full Name –** ____/____/_____ **Date of Signature at the Office**

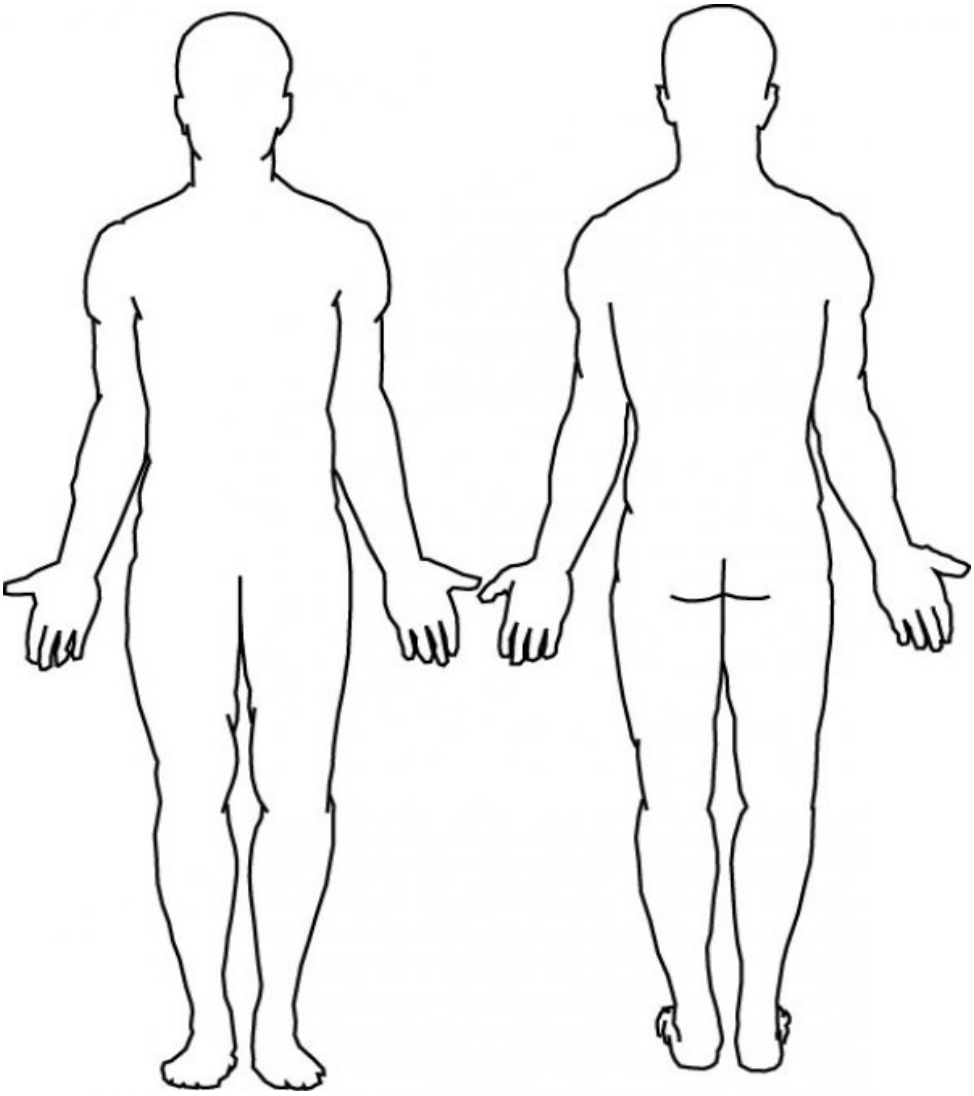
Fort Worth Chiropractic Clinic, PLLC

Pain Questionnaire

Name: _____ Date:_____

Use the letters below to indicate the type and location of your sensations you are feeling right now:

A: Aches	B: Burning	P: Pins & Needles
N: Numbness	S: Stabbing	O: Other



"Gap in Care Form – Initial Gap in Care"

(If There Were More than 2 Weeks Gap in Time Between Accident Date and First Visit)

Version 06 | Last Updated: February 26, 2022

Periodically, we may request that you complete "Gap in Care" forms at our Office. The purpose of the forms is to help us document any notable events or other factors which played a part – or may play a part – in your healthcare decision-making, such as your decision to present to our office when you did, unexpected gaps in care, etc. Payers commonly request this information in conjunction with claims we may submit to them on your behalf.

Patient's Name: _____ Date of Birth: ____/____/_____ Date of Accident: ____/____/_____

Date / Approx. Date of Your First Visit at **Our** Office Relating to Your Accident: ____/____/_____

Date / Approx. Date of Your First Visit at **THE FIRST CLINIC** You Presented for Care Relating to Your Accident: ____/____/_____

Initial Gap – Please Describe Reasons for Initial Gap

__ It wasn't clear whether adjuster was accepting full responsibility

__ Confused as to the overall process

__ Didn't know who to see for treatment

__ Didn't know how medical bills would be paid

__ Wanted to see if pain would decrease on its own

__ Pain kept increasing since date of the accident

__ Was taking pain medications, but condition didn't go away

__ Was receiving treatment by others

__ Thought I might lose my job / get demoted

__ Concerned about treatment interfering with work

__ Was traveling during the interim

__ Scared to drive after accident

__ Had no means of transportation

__ Other – Describe:

Comments:

Patient Signature: _____ Date: ____/____/_____

Parent / Guardian Signature: _____ Date: ____/____/_____