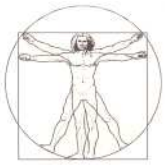

Alternative Chiropractic Solutions

Traumatic Injuries Sports Injuries Family Care Impairment Ratings Chiropractic Orthopedics
Graston Technique Low Force Activator Methods Traditional Chiropractic LASER

John H. Riggs III, D.C., Clinic Director

PATIENT CONFIDENTIAL INFORMATION

NAME (Last, First, Middle Initial): _____ **Sex**: ☐ M ☐ F **Date**: _____
STREET ADDRESS: _____ZIP: _____
HOME PHONE: _____**WORK PHONE**: _____**CELL PHONE** _____
SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH**: _____ **AGE**:_____
MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **ANY CHILDREN?**_____
EMERGENCY CONTACT: Name: _____ Address: _____
Phone number: _____ Relationship: ☐ parent ☐ spouse ☐ sibling ☐ guardian ☐ other
PATIENT'S EMPLOYER: _____ **OCCUPATION**:_____
EMPLOYER'S ADDRESS: _____
CITY: _____ **STATE**: _____ **ZIP**: _____
HOW DID CHOOSE US? ☐ Referred by_____ ☐ PHONE BOOK ☐ INTERNET ☐ OTHER____
MAIN COMPLAINTS: _____ **ONSET DATE**: _____
We ask you to please provide us with your E-MAIL address: _____
Please fill out the following INSURANCE information:

INSURANCE CARRIER'S NAME: _____
PRIMARY INSURED DATE OF BIRTH: _____
CITY: _____ STATE: _____ ZIP: _____
INSURANCE CARRIER'S AGENT'S NAME: _____
EMPLOYER'S PERSON TO CONTACT FOR INSURANCE PURPOSES: _____

CONSENT TO EXAMINATION AND TREATMENT

I hereby request and consent to examination and treatment by John H. Riggs III, D.C. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. Risks reported in the literature include: failure to improve, increased pain, in rare cases injury, bruises and fractures, as well as very rarely stroke and death from forceful neck manipulation. I understand and am informed that Dr. Riggs will make every effort to avoid any complications in the course of my treatment. Standard examination, orthopedic and neurological evaluation procedures will be used to evaluate me. I understand Dr. Riggs will select the treatment plan he feels best suited for my case. The primary treatment methods of the clinic are low force and therefore have very few complications. Traditional manipulation is used with patients preferring this method and may have more risks. I understand Dr. Riggs will discuss any concerns I have about my treatment at any time. Referral to medical specialists may be made as necessary.

I have read, or have had read to me the above consent. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment in this clinic.

I prefer the following treatment/adjusting method(s): Please check any that apply
☐ Low force-(Soft Touch or Activator) ☐ Traditional chiropractic ☐ Flexion/Distraction (Cox)
☐ I prefer the Doctor select the best method

Patient Name (Please Print): _____
Patient/Legal Guardian Signature: _____ Date: _____

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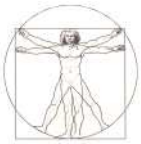

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YOUR NAME: _____ **DATE:** _____

YOUR HEALTH/INJURY HISTORY

Welcome to our office. ***Please put your name and the date at the top of <u>each</u> page****. Try to answer <u>all of the following questions to the best of your ability</u>. We thank you for your cooperation.*

TYPE INJURY/COMPLAINT:

How were you injured, or how did your complaints start?
[ ] Motor Vehicle Collision ( ) Injury (sports/work/slip & fall) ( ) Other_____

PAST/CURRENT MEDICAL HISTORY:

<u>PREVIOUS HOSPITALIZATIONS, SURGERIES, BIOPSIES, FRACTURES</u>? [ ] Yes [ ] No. If yes, please describe below and give the month/year if known_____
_____ _____

<u>PREVIOUS TRAUMA, NECK, BACK, JOINT PAIN</u>? [ ] Yes [ ] No. If yes, describe the previous injury briefly below and indicate the *year* and indicate if complaints resolved.
[ ] Vehicle Accident/Whiplash/Work Injury/Abuse_____
[ ] Slip/Fall/Sports Injury: _____
[ ] History of neck, back, joint pain, : _____
Any residuals or disability? [ ] Yes [ ] No. List _____
<u>CURRENT MEDICATIONS</u>? [ ] Yes [ ] No. If yes, please list/name below.
[ ] Pain Killers _____ [ ] Muscle Relaxers/Arthritis_____
[ ] Nerve Pills _____ [ ] Anti-Depressants_____
[ ] Antibiotics _____ [ ] Hormones/steroids_____
[ ] Blood Pressure/Heart/Blood thinners_____
[ ] Diabetes _____ [ ] Other Medications_____
<u>ALLERGIES</u>? [ ] Yes [ ] No If yes, are you allergic to: [ ] Drugs [ ] Airborne pollens [ ] Other
Please list what you are allergic to: _____

SOCIAL/FAMILY/WORK HISTORY:

<u>FAMILY MEDICAL HISTORY:</u> Please indicate any family health problems below.

<u>Relationship</u>	<u>Current Age or Age Died</u>	<u>Illnesses</u>	<u>Cause of Death</u>
Father			
Mother			
Brother(s)/Sisters(s)			

<u>HEALTH HABITS</u>? Do you use any of the following [ ] Yes [ ] No. If yes, check and circle.
[ ] Cigarettes/tobacco/chew/dip ____ packs/cigarettes/day (circle one).
[ ] Alcohol: [ ] socially, [ ] occasional, _____drinks/day (beer/wine/hard liquor-circle one)
[ ] Drugs: marijuana/speed/tranquilizers/heroine/other (circle any that apply)_____
<u>EXERCISE?</u> [ ] none [ ] regular [ ] occasional ***Type***: [ ] aerobic [ ] sports [ ] other _____
<u>WORK?</u>: **Type**? [ ] Desk/Sedentary [ ] Standing [ ] Heavy Labor [ ] Light Labor [ ] Don't work
<u>OTHER TREATMENT?</u>
Have you seen any other health care providers for this conditions? [ ] Yes [ ] No
If yes, what type? [ ] Chiropractor [ ] Medical Doctor [ ] Specialist
Any x-rays/MRIs done? [ ] Yes [ ] No Any treatment? [ ] Therapy [ ] Medications
Any Labs done? [ ] Yes [ ] No.

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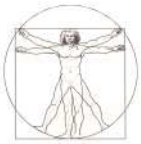

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YOUR NAME: _____ **DATE:** _____

REVIEW OF BODY SYSTEMS. Please *check or circle* any problems or major illnesses that apply.

GENERAL/CANCER	[ ] Previous or current history of cancer. Type: _____ [ ] Unexplained weight loss, bowel or bladder changes, [ ] Sore than doesn't heal [ ] Abnormal bleeding/discharge [ ] Lump/thickening/mass	[ ] Indigestion or difficulty swallowing [ ] Changes in wart or mole [ ] Persistent, nagging cough or hoarseness or rust colored sputum [ ] Night pain [ ] Unusual weakness, fever, chills [ ] Recent colds, flues, viruses
HEARING, EYES, NOSE, THROAT	[ ] Sinus problems [ ] Sore throat [ ] Chronic cough	[ ] Nosebleeds [ ] Ear discharges [ ] Glaucoma
LUNGS, HEART, CIRCULATION, BLOOD	[ ] Chest Pain [ ] Heart attack [ ] High Cholesterol [ ] High blood pressure [ ] Swelling in feet or hands [ ] Clots or clotting difficulty	[ ] Varicose veins [ ] Irregular or rapid heartbeat [ ] Fainting [ ] Asthma or emphysema [ ] Tuberculosis [ ] Pneumonia or bronchitis
DIGESTIVE TRACT	[ ] Constipation [ ] Stomach pain [ ] Reflux/heartburn/Ulcers [ ] Diarrhea/ Irrit. Bowel/Crohn's	[ ] Gallbladder problems [ ] Liver problems/Hepatitis/jaundice [ ] Excessive Gas [ ] Appendicitis
GENITAL/URINARY	[ ] Blood in urine [ ] Excessive urination or frequency [ ] Urinary difficulty [ ] Bladder problems (control, infections) [ ] Kidney problems (stones, infections)	***Women***: Irregular periods, excessive bleeding, pelvic pain, fibrocystic breast disease. **Are you pregnant**? Yes/No Last Period: _____ ***Men***: prostate cancer, enlarged prostate, testicle lumps ***Venereal Diseases***: AIDS/ARC, gonorrhea, syphilis, venereal warts
SKIN/GLANDS	[ ] Skin allergies, rashes [ ] Swollen glands [ ] Bruising/cuts	[ ] Itching skin [ ] Psoriasis [ ] Hernias/Lumps
NEUROLOGICAL	[ ] Stroke [ ] Dizziness/Vertigo [ ] Double or blurry vision [ ] Speech Difficulty [ ] Depression/Nervousness [ ] Tremors/shaking	[ ] Migraine [ ] Clumsiness [ ] Memory Loss/Confusion [ ] Black outs/Fainting [ ] Unusual headaches [ ] Concussion/Epilepsy
MUSCULOSKELETAL	[ ] Arthritis (osteo/rheumatoid) [ ] Neck/Back Injuries/herniation [ ] Joint Pain/Stiffness	[ ] Muscle pain, aching, cramps [ ] Fibromyalgia [ ] Night leg pain
HORMONES/IMMUNE SYSTEM	[ ] Female hormone problems [ ] Thyroid (low/high)/Goiter	[ ]Diabetes/hypoglycemia [ ] Mono
MAJOR DISEASES/ILLNESSES	[ ] Parkinson's/Huntington's [ ] Multiple Sclerosis/Guillan-Barre, Alzheimer's	[ ] Lupus/Scleroderma [ ] Leukemia/Multiple Myeloma [ ] Polio/Chicken Pox/Mumps

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YOUR NAME: _____ DATE: _____

Your Chief Complaints

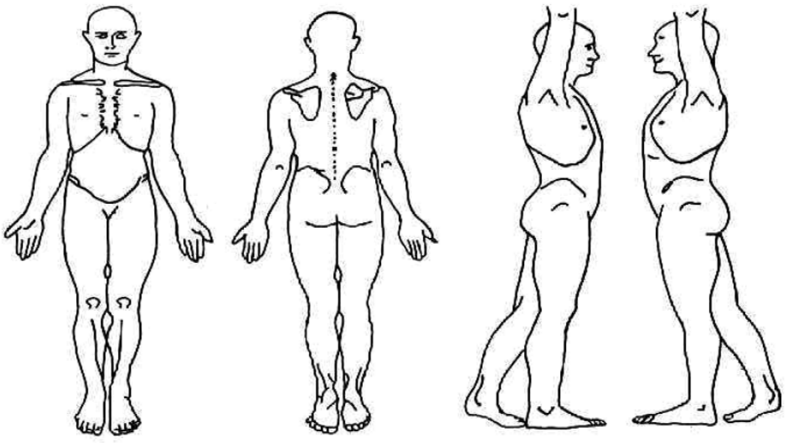
1. When did you start having symptoms? Date? _____ Other:_____
2. What caused your symptoms? [ ] accident [ ] work [ ] sports [ ] normal activities [ ] unknown [ ] fall [ ] other _____

Pain Drawing

Please mark on the body below where you are having symptoms and answer the following.

Describe how your symptoms began.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



For the following answer the questions about the frequency (during the day), and the type and intensity of your pain.

NECK PAIN/HEADACHE (circle one or both):
How Often? [ ] Constant (76-100%), [ ] Frequent (51-75%), [ ] Occasional (26-50%) [ ] Intermittent (0-25%)
Type Pain? [ ] Sharp [ ] Dull Ache [ ] Burning [ ] Numb [ ] Tingling [ ] **Radiating to** [ ] Shoulder [ ] Elbow [ ] Hand
How Strong (0-10)? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

OTHER UPPER BODY COMPLAINTS: [ ] Shoulder Pain [ ] Elbow Pain [ ] Wrist/Hand Pain
How Often? [ ] Constant (76-100%), [ ] Frequent (51-75%), [ ] Occasional (26-50%) [ ] Intermittent (0-25%)
Type Pain? [ ] Sharp [ ] Dull Ache [ ] Burning [ ] Shooting [ ] Numb [ ] Tingling
How Strong (0-10)? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

MID BACK PAIN (from across your shoulders to the bottom of your ribs)
How Often? [ ] Constant (76-100%), [ ] Frequent (51-75%), [ ] Occasional (26-50%) [ ] Intermittent (0-25%)
Type Pain? [ ] Sharp [ ] Dull Ache [ ] Burning [ ] Numb [ ] Tingling [ ] **Shooting/Radiating to** [ ] Ribs [ ] Chest
How Strong (0-10)? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

LOW BACK PAIN/SACROILIAC PAIN (from the bottom of your ribs to your hips):
How Often? [ ] Constant (76-100%), [ ] Frequent (51-75%), [ ] Occasional (26-50%) [ ] Intermittent (0-25%)
Type Pain? [ ] Sharp [ ] Dull Ache [ ] Burning [ ] Shooting [ ] Numb [ ] Tingling [ ] **Radiating to** [ ] Knee [ ] Foot
How Strong (0-10)? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

OTHER LOWER BODY COMPLAINTS: [ ] Hip Pain [ ] Knee Pain [ ] Ankle/Foot/Toe Pain
How Often? [ ] Constant (76-100%), [ ] Frequent (51-75%), [ ] Occasional (26-50%) [ ] Intermittent (0-25%)
Type Pain? [ ] Sharp [ ] Dull Ache [ ] Burning [ ] Shooting [ ] Numb [ ] Tingling
How Strong (0-10)? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

WHAT DAILY ACTIVITIES ARE BEING AFFECTED? [ ] Walking [ ] Sitting [ ] Standing [ ] Sleeping [ ] Working [ ] Bathing [ ] Household Chores [ ] Driving [ ] Exercise [ ] Other _____

Signature_____ Print Name: _____ Date: _____

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John H. Riggs III, D.C., Clinic Director

Insurance Assignment of Benefits

Date: _____

Patient: _____

Employer: _____

Claim Group: _____

SS#/ID#: _____

Insurance Company: _____

The Texas Insurance Code, Article 21.24-1, Section 4 (a) states: **"If a written assignment of benefits for health care services is submitted with the claim, the benefit payments shall be made by the insured directly to the health care provider."** Therefore, I hereby instruct and direct the above named insurance company to pay by check made out and mailed to the following, or if my current policy or third party coverage does not require compliance with Texas law and prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

John H. Riggs III, D.C.
Alternative Chiropractic Solutions
4610 N. Garfield Street, B4
Midland, TX 79705-2652

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy or third party insurance coverage as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

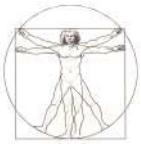
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, authorized third party, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I also authorize the above doctor to deposit checks received on my account when made out to me for payment of services owed.

Dated at Midland, TX this _____ day of _____, 2012

_____ _____
Signature of Policyholder/Claimant Witness/Notary



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

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed ____/____/____ Witness: _____

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