

Rio R. De Leon, D.C.
Jarrod M. Cashion, D.C.
Marcy Halterman, D.C., J.D.
Timothy J. Bolton, D.C.



Welcome to Our Office !

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

Patient Data

Date: _____

Name: _____ **Sex: Male or Female** **Home Phone:** _____

Personal Email: _____ **Cell Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Birthday: ___/___/___ **Age :** _____ **Marital Status: M S W D** **No. of Children:** _____

Social Security Number: _____ **Driver License Number:** _____

Employer: _____ **Position:** _____ **Work Phone:** _____

SPOUSE: _____ **Employer:** _____ **Work Phone:** _____

IN CASE OF EMERGENCY: NAME OF NEAREST RELATIVE OR FRIEND

1. _____ **Phone:** _____

How were you referred to our office? ___ Doctor (Name/Specialty) _____
Yellow Pages: ___ (Maroon) Area Wide ___ (White) Verizon ___ TV ___ Radio
Person (name) _____ OTHER _____

CURRENT HEALTH CONDITIONS

Please describe your chief complaint / what brought it on? _____

When did this condition begin? _____ Was it (gradual / sudden) ? _____

Have you had any treatment for this condition? If so, please tell us when, where, with whom, and what were the results ? _____

Is your pain (Improved-Worsened-Unchanged) by the following activities: (**indicate by "I"- "W"- "U"**)

___ Activity ___ Inactivity ___ Cough/Sneeze ___ Sitting in Chair/Car ___ Stand/Walk ___ Bending
___ Twisting ___ Kneeling ___ Lay on Back ___ Lay on Side ___ Lay on Stomach ___ Reaching

What is the nature of your pain? **Constant / "Comes and Goes" / Sharp / Dull / Burning**

Does your pain refer to other parts of your body? **Yes or No** Grade your pain from **0(none) to 10** _____

Is your pain (**Improved / Worsened / Unchanged**)? In the ___ Morning ___ Afternoon ___ Evening ___ Night

Is this condition interfering with your ___ Work ___ Sleep ___ Daily Routine?

Is this condition Work related injury or auto injury? _____

What have you done to get relief? _____

What type of bed do you sleep on? (Waterbed, soft mattress, etc.) _____

What kind of pillow do you use? (Thick foam, thin goose down, etc.) _____

Do you sleep on your _____ side _____ back _____ stomach

Do you exercise? (**work doesn't count !**) **YES or NO** - If so, what do you do and how often?

Do you smoke? **YES or NO** - If so, how many packs a day ? _____

Are you under a lot of stress at the present time? **YES or NO** _____

Choose **ONE**:The primary reason I brush my teeth is to: __Avoid tooth decay __For healthy teeth and gums

MEDICAL HISTORY

Do you or any member of your immediate family have or had any of the following?

Please Indicate: Myself: "P" – Past "C" – Current or "F" Family

_____ HIGH BLOOD PRESSURE	_____ MUSCULAR DYSTROPHY	_____ RHEUAMTIC FEVER
_____ HEART TROUBLE	_____ MULTIPLE SCLEROSIS	_____ SCARLET FEVER
_____ DIABETES	_____ CONVULSIONS	_____ POLIO
_____ HEPATITIS	_____ EPILEPSY	_____ TUBERCULOSIS
_____ VENEREAL DISEASE	_____ CONCUSSION	_____ ANEMIA
_____ HIV	_____ CANCER	_____ OTHER:

The following are conditions that chiropractic may often help. Please mark an "X" if you CURRENTLY have any of the following and please mark "P" if any you have had in the PAST:

_____ DIZZINESS	_____ NUMBNESS
_____ BACKACHES	_____ ALLERGIES
_____ DIGESTIVE PROBLEMS	_____ SINUS PROBLEMS
_____ ARTHRITIS	_____ ASTHMA
_____ PAIN BETWEEN SHOUDLERS	_____ NERVOUSNESS
_____ NECK PAIN/ STIFFNESS	_____ HEADACHES

Date and purpose of last chiropractic treatment _____

Name of Last Doctor of Chiropractic : _____

Date of Last X-rays / MRI: _____ Where ? _____

Are you pregnant ? **YES or NO** Date of Last Menstrual Period ? _____

Please list any vitamins, laxatives, or herbs you are taking ? _____

Have you had prior surgeries? _____

Are you allergic to any medication? **YES/NO** What kind ? _____

Indicate which medications you are currently taking:

___ Nerve Pills (Anti-Depressants)	___ Pain Killers	___ Insulin	___ Birth Control Pills
___ Muscle Relaxants	___ Anti-inflammatory	___ Anticoagulants	___ Blood Pressure Medication
___ Female Hormones	___ Thyroid Medication	___ Antibiotics	___ Cholesterol Medication

I understand and agree that health insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all service rendered to me are charged directly to me and that I am personally responsible for payment., I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. **I also understand that a 1.0% interest per month will be assessed on any cash balances over 30 days (ie cash account, co-payments, payment plans and personally injury/liability cases)**

NOTE Returned checks will be assessed a \$25.00 fee.

Signature: _____

Date: _____

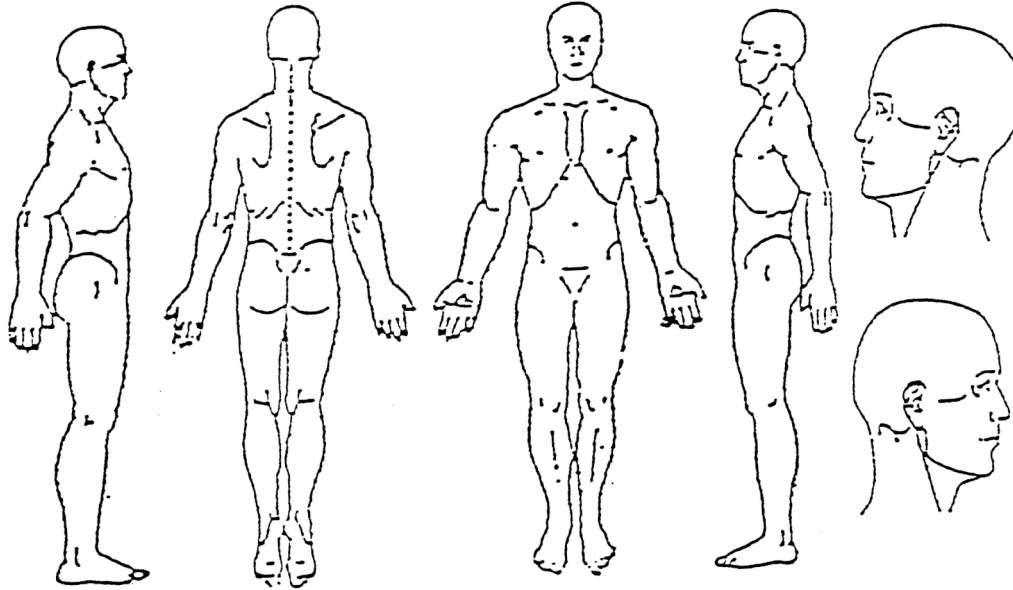
NOTE: Treatment may be suspended for non- payment of services rendered.

In-Office Appointment:

Date	Time

PAIN DRAWING (Please indicate the areas in which you are presently experiencing pain by drawing in the letter abbreviations that most accurately reflects the type of discomfort you have.)

N = Numbness T = Tingling P = Pain-Sharp B = Burning D = Dull Pain S = Stiffness
Z = Cramping

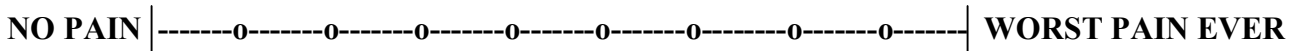


Please rate the pain that you are experiencing today by using the scale below:

Using the **SCALE** of 0-100 with 0 = NO PAIN and 100 = Worst possible pain, **Please write** the number indicating your **present pain level** in the box to the right

→

Also, **please place one mark** on the line below to indicate your **present pain level**:

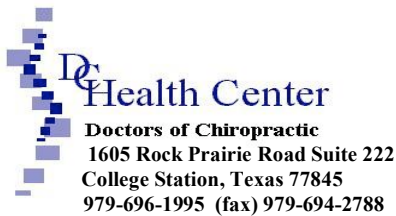


PLEASE list or describe in the space below, any new symptoms that you are experiencing or any changes in your condition that you feel the doctor should be aware of in relation to you case.

PATIENT NAME (PRINT): _____ PATIENT SIGNATURE: _____

BELOW FOR DOCTORS USE ONLY:

SUBJECTIVE FINDINGS : "Patient stated that..."



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Consent To Treatments

By signing this form, I am requesting and consenting to the diagnostic and therapeutic procedures which may include, but are not limited to, physical modalities, x-rays, physical examination and history and chiropractic treatment performed by the doctors of D.C. Health Center, L.L.P and staff. I understand that it is my right to determine the extent of my medical care, and I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment.

I recognize that no guarantees have been or can be made regarding the likelihood of success of the outcome of any evaluation, treatment, test, procedure, or therapy performed by D.C. Health Center, L.L.P doctors of chiropractic or staff.

Verification of Pregnancy:

_____ **INTIAL** By signing this form, I certify that, to the best of my knowledge, **I am not pregnant** and the above doctor(s) and/or associates have my permission to perform diagnostic X-ray examination. I have been advised that X-rays can be hazardous to an unborn child.

_____ **INTIAL** By signing this form, I am affirming that **I am pregnant** and my due date is _____. I consent the above doctor(s) and/or associate to perform the necessary chiropractic manipulative therapy and/or adjunctive therapy.

NOTE: There has been a risk factor documented in the medical literature of 1:600,000 to 1:6 million (the greater risk depending in whether you are a woman that smokes and is on birth control pills) of a stroke type accident due to neck manipulation. There also might be some discomfort in areas that have never been treated chiropractically after your first adjustment. By signing this form, I understand this and will talk to the doctor(s) regarding any concerns I may have regarding this.

Authorized Signature: _____

Date: _____



Nicerio R. DeLeon, D.C. Jarrod M. Cashion, D.C. Marcy Halterman, D.C. Timothy J. Bolton, D.C.
1605 Rock Prairie Road, Suite 222 College Station, Texas 77845 Phone 979-696-1995

Financial Policy

- ❖ Appointments/Cancellations: Please be 5 minutes early for your appointment. Each patient is scheduled an individual time slot. If you are late, or cancel without 24 hours notice this causes other patients to be late or denied an appointment when they might otherwise be seen. You will be financially responsible for all missed appointments or untimely cancellations. **Initials** _____
- ❖ All payments are due at the time that the service is rendered. Patient visits include heat, treatment, rehabilitation (if necessary) & ice. If ancillary services are required (Ultra Sound, Electrical Muscle Stim, Laser or Decompression Therapy) during your visit, there will be an additional fee. We accept cash, checks, MasterCard, Visa, Discover and American Express.
- ❖ If you have out-of-network chiropractic benefits, we do accept most health insurance plans. Due to the numerous variations in individual coverage, all acceptances will be on a case-by-case basis. If we do not file your insurance claim, you will be provided an invoice so that you can file any insurance claims and be reimbursed directly.
- ❖ Our fees are considered usual, customary and reasonable by most insurance companies and are therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to insurance companies that reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
- ❖ If your carrier has not paid a claim within **sixty- (60)** days of submission, you agree to take an active role in the recovery of your claim. If your carrier has not paid within **ninety- (90)** days of submission or denies a claim based on benefits, you accept responsibility for payment of any outstanding balance. **Initials** _____
- ❖ Personal injury/auto claims may also be handled through your personal injury protection (PIP) insurance.
- ❖ MEDICARE/MEDICAID, We do verify that your insurance covers chiropractic, that your deductible has been met and what percentages of payment and coverage will be. You will need to pay in full for the first visit if we cannot verify your insurance.
- ❖ MANAGED CARE WAIVER: I understand that in the opinion of the doctors at D.D Health Center the services of items, supplies, and durable medical equipment that I have requested to be provided to me may not be covered by my commercial insurance, or my managed health care plan. If my charge(s) is (are) determined by my insurance carrier to be outside of my network or not a covered charge, I understand that I will be responsible for payment for these services because they are reasonably and medically necessary for my care. As per Medicare guidelines, any chronic conditions treated by chiropractic, run a possibility of not being paid for by Medicare. "The manipulation codes 98940, 98941, 98942 may be denied by Medicare if deemed a chronic condition". If treatment is denied, payment is your responsibility or your secondary insurance if applicable.

Patient's Name (Printed) _____ Date _____

Patient/Guardian Signature _____ Relationship to Patient _____



1605 Rock Prairie Rd. #222 - College Station, TX 77845

979-696-1995 (fax) 979-694-2788

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

_____ (Name), 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 its 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
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Relationship

Date Signed ____/____/____

Witness: _____

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list the 5 major health concern in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number “0 - 3” on all questions below. 0 as the least/never to 3 as the most/always.

Category I (Colon)				Category V (Bile Enzymes)					
Feeling that bowels do not empty completely	0	1	2	3	Greasy or high fat foods cause distress	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3	Lower bowel gas and or bloating several hours after eating	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Diarrhea	0	1	2	3	Unexplained itchy skin	0	1	2	3
Constipation	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Hard dry or small stool	0	1	2	3	Stool color alternates from clay colored to normal brown	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
use laxatives frequently	0	1	2	3	Have you had your gallbladder removed	Yes	No		
Category II (Gastric Enzymes)				Category VI (Blood Glucose Fluctuation)					
Excessive belching, burping, or bloating	0	1	2	3	Crave sweets during the day	0	1	2	3
Gas immediately following a meal	0	1	2	3	Irritable if meals are missed	0	1	2	3
Offensive breath	0	1	2	3	Depend on coffee to keep yourself going or started	0	1	2	3
Difficult bowel movements	0	1	2	3	Get lightheaded if meals are missed	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Eating relieves fatigue	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3	Feel shaky, jittery, tremors	0	1	2	3
Category III (Gastric Irritation)				Category VII (Insulin Resistance)					
Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3	Fatigue after meals	0	1	2	3
Do you frequently use antacids	0	1	2	3	Crave sweets during the day	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Must have sweets after meals	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3	Frequent urination	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3	Increased thirst & appetite	0	1	2	3
Category IV (Pancreatic Enzymes)				Category VIII (Adrenal Fatigue)					
Roughage and fiber cause constipation	0	1	2	3	Cannot stay asleep	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3	Crave salt	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3	Slow starter in the morning	0	1	2	3
Excessive passage of gas	0	1	2	3	Afternoon fatigue	0	1	2	3
Nausea and/or vomiting	0	1	2	3	Dizziness when standing up quickly	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3	Afternoon headaches	0	1	2	3
Frequent urination	0	1	2	3	Headaches with exertion or stress	0	1	2	3
Increased thirst and appetite	0	1	2	3	Weak nails	0	1	2	3
Difficulty losing weight	0	1	2	3					

Category IX (Cortisol Elevation)

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X (Thyroid – Decreased Metabolic Activity)

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over .	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI (Thyroid – Increased Metabolic Activity)

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII (Pituitary - Decreased Metabolic Activity)

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII (Pituitary - Increased Metabolic Activity)

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males Only) -Prostate

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only) - Male Hormones

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional then in the past	0	1	2	3

Category XVI (Menstruating Females Only) - Female Hormones

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Hormones)

How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III

How many alcohol beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Do you smoke? _____ If yes, how many times a day _____, a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: