All Family CHIROPRACTIC

Health Questionnaire

Please Print

Today's Date_____

__Mr. __Mrs. __Ms. Last Name _____First Name _____MI____

Address_____ Birth Date _____/_____/_____

City _____ State_____ Zip_____ Home #_____ Cell #_____

Work #_____ Marital Status: ___Married ___Single ___Widowed ___Divorced ___Separated

Employer _____ Job Title_____

Type of work you do_____

Spouse's Name_____Spouse's Birth Date _____/_____/_____

Spouse's Employer_____ Spouse's Job Title_____

No of Children _____ Names of Children _____

Who is responsible for your bill? ___Self ___Spouse ___Employer ___Insurance

How will payment be made? __Cash __Worker's Comp __Health Insurance __Medicare __Medicaid __Auto Insurance

Most of our patients are referred to our office by family, friends or doctors. Who can we thank for referring you?

_____

Who is your PCP (Primary Care Physician/Practitioner)? _____ Phone #_____

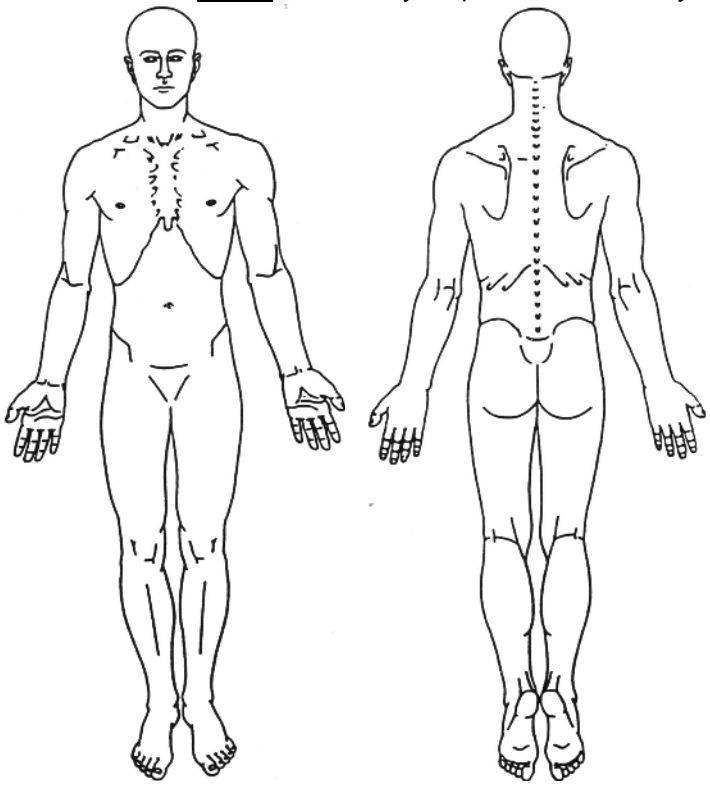
Insured Name (if other than self-i.e. parent/spouse) _____ Insured/Parent Date of Birth _____/_____/_____

Insured/Parent Permanent Address (if other than above) _____

City _____ ST_____ Zip_____ Insured/Parent SSN _____ Insured/Parent Employer _____

Insured/Parent Home # _____ Insured/Parent Work # _____ Insured/Parent Cell # _____

Please Mark the **exact** location of your pain, stiffness or symptoms on this diagram. (Use key listed below)



Key: A = Ache B= Burning N = Numbness
P=Pins & Needles S=Stabbing O= Other

Please describe your major complaints; with regards to the type and frequency of your pain, stiffness or symptoms. For example: dull, sharp, constant, off, on, etc.

_____

_____

_____

_____

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On a scale of 0-10, with “0” being “no pain, stiffness, tightness or numbness” and “10” being “the worst imaginable pain”, please **circle** the number below that applies to your level of pain or symptom. **No Pain 1 2 3 4 5 6 7 8 9 10 Worst Imaginable Pain**

When was the first time you were aware of any symptoms? _____

How did this condition develop? (What caused it? How did it start? What were you doing when the pain started?) _____

_____

_____

Have you ever had this problem or a similar problem before? □ **Yes** □ **No** If yes, explain _____

_____

Science tells us your spine, like your teeth, need to be cared for regularly.

When was your last spinal exam including x-rays? _____/_____/_____ □**Never**

How often do you get adjusted by a chiropractor? □**Frequently** □**Only when I hurt** □**Monthly** □**Never**

Have you consulted a Chiropractor in the past? □ **Yes** □ **No** If YES: NAME: _____

Date consulted: _____ For what problem? _____

Do you know if you have a spinal curvature? □ **Spinal Arthritis** □ **Inherited Spinal Problem** □ **Other** _____

Over time spinal misalignments will cause arthritis and degeneration, which result in grinding or cracking to be heard when you move your neck or back, as well as loss of nerve health.

Do you hear these sounds when you move your head, neck or back? □ **Yes** □ **No**

If your spine is out of alignment for a long time it can make you feel like you need to stretch, twist, or crack your neck or back.

Do you often feel the need to crack or pop your neck or back? □ **Yes** □ **No**

Poor Posture leads to poor health and early death. How would you rate your posture? **Poor 1 2 3 4 5 6 7 8 9 10 Excellent**

Stress causes your spine to misalign and accelerate spinal damage. Rate your stress level. **None 1 2 3 4 5 6 7 8 9 10 Intense**

List surgeries you have had from birth to now, in chronological order with your age at time of surgery._____

_____

_____

Daily trauma, auto accident(s), and work injuries can cause misalignment of vertebrae and serious spinal problems.

When was your most recent injury at home/work? _____ Car accident? _____

Slip or fall? _____

Spinal health is vitally important to ensure you and your baby are healthy. Are you pregnant? □ **Yes** □ **No**

Improper sleeping positions can cause spinal misalignment. What is your sleeping position? (Check all that apply)

□**Back** □**Stomach** □**R. Side** □**L. Side**

Are you □**Right Handed** □**Left Handed**

Work Habits (Pick One)? □**Full - Time** □**Part - Time** □**Homemaker** □**Retired** □**Student** □**Unemployed** □**Disabled**

Alcohol Usage (Pick One)? □**Do Not Drink** □**Social Drinker** □**Light Drinker** □**Moderate Drinker** □**Heavy Drinker** □**Alcoholic** □**Recovering Alcoholic**

Caffeine Intake (Pick One)? □**Do Not Drink Caffeine** □**Drink Caffeine Weekly** □**Drink Caffeine Occasionally** □**Drink 1 Cup of Caffeine in morning** □**Drink 2-4 cups of Caffeine per Day** □**Drinks 5 or more Cups of Caffeine per Day**

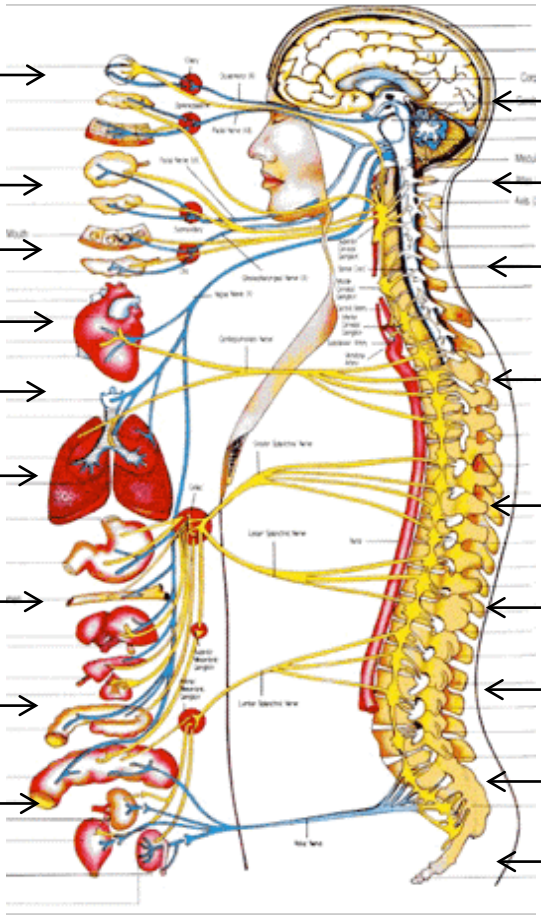
Recreational Drug Usage (Pick One)? □**Do Not Use Recreational Drugs** □**Light Use of Recreational Drugs** □**Moderate Use of Recreational Drugs** □**Heavy Use of Recreational Drugs** □**Drug Addicted** □**Recovering Drug Addict**

Exercise Routine (Pick One)? □**Daily** □**Every Other Day** □**Few Times a Week** □**Occasionally** □**Once a Week** □**Almost Nothing**

Subluxation (misalignment) of the spine will lead to health problems in your body.

Please CIRCLE or check any health symptoms or health complaints you are experiencing.

Headaches/Migraines
Dizziness
Loss of Balance/Vertigo
Allergies
Thyroid
High Cholesterol
High Blood Pressure
Arm Pain L/R
Asthma
Shortness of Breath
COPD/Emphysema
Chronic Cough
Lung Disease
Bronchitis
Lower Back Pain
Menstrual Pain
Excessive Menstruation
Irregular Menstrual Cycle



Frequent Colds
Sinus Issues
Eye Pain
Neck Pain
Chest Pain
Heart Disease
CHF
Irregular Heartbeat
Mid Back Pain
Ulcers
Reflux
Infertility
Gall Bladder
Prostate
Frequent Urination
Leg Pain L/R
Sciatica
Digestive (IBS / Constipation)

Anxiety/Depression

Auto Immune Disease

Allergies:

_____

_____

_____

_____

Have you had any of these Cardiovascular Diseases? Check all that apply.

- ☐ Myocardial Infarction
- ☐ Bypass Surgery
- ☐ Coronary Artery Disease

Do you have Diabetes? If so what type?

- ☐ Type I
- ☐ Type II
- ☐ Juvenile

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cataracts
- ☐ Cold Extremities
- ☐ Cramps
- ☐ CVA (stroke/TIA)
- ☐ Dementia/Alzheimer's
- ☐ Diagnosed emotional/mental
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Glaucoma
- ☐ Gout
- ☐ Hemorrhoids
- ☐ Hot Flashes
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Liver Disease/Cirrhosis
- ☐ Loss of Memory
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Macular Degeneration
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Polio
- ☐ Retinal Disease
- ☐ Seizures
- ☐ Skin Sensitivity
- ☐ Sleep Problems/Insomnia
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Chiropractic Care is important to restore your health, are you committed to following the recommendations necessary to correct your problem ☐ **Yes** ☐ **No**

Fees are payable at the time x-rays, examination, and treatments are received unless other arrangements are made in advance. X-rays remain the property of this clinic.

X _____ X _____

Patient's Signature Date

X _____ X _____

Social Security Number Driver's License Number

Dr. Andrew P. Azab
All Family Chiropractic & Injury Clinic
3903 98 th Street, Suite 100
Lubbock, TX 79423

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name:_____ Email address: _____@_____

Preferred method to receive preventative health information (Circle one): Email / Phone / Mail

DOB: _____/_____/_____ Gender (Circle one): Male / Female **Preferred Language: _____**

Smoking Status (Circle one): □Every Day Smoker □Occasional Smoker □Former Smoker □Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): □American Indian or Alaska Native □Asian □Black or African American □White (Caucasian)
□Native Hawaiian or Pacific Islander □I Decline to Answer

Ethnicity (Circle one): □Hispanic or Latino □Not Hispanic or Latino □I Decline to Answer

Prescription medications can cause various side effects, hide the severity of health problems, and hinder the body's ability to heal. What medications are you currently taking? (If you have a list please attach):

Medication Name	Dosage & Frequency	Reason for taking Medication	Additional Comments

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank because of the nature and frequency of chiropractic care.)*

Patient Signature: X _____ Date: X _____

AUTO ACCIDENT QUESTIONNAIRE

Name: _____ Date of Accident: _____ Time: _____

Please describe the accident in your own words: _____
_____
_____
_____
_____

Please answer the following questions regarding your accident and injury.

1. Were you wearing a seat belt? ___Yes ___No
   What type of seat belt? ___Lap ___Shoulder
2. What was your position in the car? ___Driver ___Passenger
   If passenger, were you: ___Front Seat ___Right Rear Seat ___Left Rear Seat
3. Did the air bag deploy? ___Yes ___No
4. Did your seat have a headrest? ___Yes ___No
   If so, what was the position of the head restraint? ___Low ___Mid-position ___High
5. Where were you looking at time of accident? ___Straight Ahead ___Right ___Left ___Down ___Up
6. Did you strike anything at the time of impact? ___Yes ___No
   What part of the body? Check all that apply: ___Head ___Chest ___Rt/Lt Shoulder __Rt/Lt Arm
   ___Rt/Lt Hand ___Rt/Lt Knee ___Rt/Lt Leg ___ Rt/Lf Foot ___Other_____
   What part of the car did you strike? Check all that apply: ___Airbag ___Seatbelt ___Dashboard
   ___Windshield ___Steering Wheel ___Door ___ Window ___Armrest ___Seat ___Headrest
7. Immediately after the accident were you? ___ Conscious ___Dazed ___Unconscious
8. Did your vehicle strike the other vehicle? ___ Yes ____ No
9. Was you vehicle struck by the other vehicle? ___ Yes ___ No
10. Where was the impact on your vehicle? ___Front ___Rear ___Side __Head-On __Unknown
11. Where was the impact on the other vehicle? ___Front ___Rear ___Side __Head-On __Unknown
12. What was the approximate speed at the time of impact?
    Your vehicle ____MPH Other vehicle _____ MPH
13. How much damage did your vehicle sustain? ___No Visible Damage ___Slight Damage
    ___Moderate Damage ___ Heavy Damage ___Totaled
14. Was your vehicle towed from the scene? ___Yes ___No
15. What were the road conditions at time of accident? ___Dry ___Wet ___Icy
16. Were both hands on the steering wheel? ___Yes ___No
    If no, which hand was on the steering wheel? ___Right ___Left
17. Was your foot on the brake? ___Yes ___No
    If yes, which foot? ___Right ___Left
18. Were you braced at time of impact (did you see the accident coming and tense up)? ___Yes ___No
19. Were police at the scene? ___Yes ___No
    If so please check all that apply: ___Citation Issued to Self/Other Party ___No Citation
    ___Arrest Made Self/Other Party ___Accident Report Completed

20. Was EMS called to the scene? ___Yes ___No
Did you leave by ambulance? ___Yes ___No
If by ambulance were you placed in a: ___Neck Brace ___Back Brace ___Other_____
If No, what did you do after the accident? ___Was Driven to Hospital ___Continued on with Activities
___Drove Home ___Arranged for Ride Home
21. Have you received any treatment since the accident? ___Yes ___No
Name of clinic/Hospital: _____
Name of Doctor: _____
Diagnosis: _____
Please check any that apply: ___ Exam was Completed ___ Medication was Prescribed
___ X-Rays Completed ___ Referred to Chiropractor/Neurologist/Orthopedist/PCP
__Released to Home __Home Treatment with Cold/Heat/OTC Medications
22. Where did you feel pain at the time of accident? Check all that apply: ___Head ___Neck
___ Rt/Lt Shoulder ___Midback ___Lower Back ___Rt/Lt Hip ___Rt/Lt Leg
Describe the pain at the time of the accident: ___Sharp ___Dull ___Nausea
I also noticed after the accident I felt: ___Anxious ___Difficulty Breathing ___Chest Pain
___Depressed ___Disbelief ___Dizziness ___Exhaustion ___Facial Pain ___Genital Pain
___Headaches ___Irritability ___Loss of Appetite ___Low Energy ___Muscle Spasm ___Numbness &
Tingling ___Rib Pain ___Shock ___Difficulty Sleeping ___Sore ___Soreness ___Stomach Pain
___Stress ___Stunned ___Tightness ___Tired ___Upset
23. Since the accident I have noticed my symptoms have: ___Resolved ___Disappeared ___Stayed the
Same ____Show No Change ___Does Not Impact my Daily Functioning at Home or Work ___Improved
___Lessened ___Less Stiff ___Less Pain ___Quality of Life has Improved ___Exacerbated ___More Pain
___More Stiff ___Quality of Life has Worsened

Patient signature X_____ Date X_____

FOR DOCTORS USE ONLY

Picture

Patient vehicle #1
Other vehicle #2

__ Requested medical records from:

1. _____
2. _____
3. _____

___ Requested accident report
___ Accident Questionnaire reviewed with patient by DR Azab

- Low Back Pain Questionnaire –The low back includes the mid back, low back, all the way down into the legs & feet. Circle one choice per section. Then, please sign and date at the bottom of the sheet.

- Neck Pain Questionnaire - The neck includes the head, neck, shoulders, all the way down into your arms & hands. Circle one choice per section. Then, please sign and date the bottom of the sheet.

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 -- Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 -- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 -- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 -- Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

SECTION 6 -- Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 -- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments: _____

_____

Patient Signature: X _____ **Date:** X _____

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity
A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

Section 2 — Personal Care (Washing, Dressing, etc.)
A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

Section 3 — Lifting
A I can lift heavy weights, without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

Section 4 — Reading
A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

Section 5 — Headaches
A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

After Vernon & Mior, 1991
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

Section 6 — Concentration
A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

Section 7 — Work
A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

Section 8 — Driving
A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

Section 9 — Sleeping
A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours sleepless).

Section 10 — Recreation
A I am able to engage in all of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

REVISED January 1, 1995

Comments: _____

_____

Patient Signature: X _____ Date: X _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the differences between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic care seeks to restore health through natural means and without the use of medicine or surgery. This approach to health care gives the human body maximum opportunity to utilize its inherent recuperative powers in the treatment process. The success of the Chiropractic Physician's procedures often depends on environment, underlying causes, physical and spinal conditions.

ANALYSIS

Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be performed in an attempt to restore spinal integrity. It is the Chiropractic premise that proper spinal alignment maximizes nerve transmission throughout the body and gives the body and opportunity to use its inherent recuperative powers. Due to the complexity of the human body, no physician can promise you specific results for Chiropractic treatment. The results obtained from Chiropractic adjustments depend upon the inherent recuperative powers of the patient's s body.

DIAGNOSIS

Although Chiropractic Physicians are experts in musculo-skeletal treatment and diagnosis, the VSS and VSC, they are not internal medicine specialist. Every Chiropractic patient should be aware of his own symptoms and secure other opinions if he has any concerns as to the nature of his total condition. Your Chiropractic Physician may advise you to seek a second opinion from another professional, but you are responsible for the final decision on such matters.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient seeking treatment form the Chiropractic Physician authorized the Chiropractic Physician to care for the patient in accordance with the Chiropractic treatment protocols. Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems for the patient. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Chiropractic Physician, of course, will not give an chiropractic adjustment or perform other procedures if he is aware that such care may be harmful to the patient. It is the patient's responsibility to disclose his health problem to the Chiropractic Physician, especially latent pathological defects, illnesses, or deformities which would otherwise not come to the Chiropractic Physician's attention. The patient should seek the treatment from the health care specialist who is qualified to provide the prober diagnostic and clinical procedures for the patient's problems. The Chiropractic Physician is licensed to diagnose and treat musculo-skeletal problems and routinely works with health care providers form other disciplines to help provide prompt and effective care for his patients.

RESULTS

The purpose of Chiropractic services is to promote natural health through the reduction of the incidence of VSS or VSC in Chiropractic patients. Since there are so may variable, it is difficult to predict the time schedule or efficacy of Chiropractic treatment. Sometimes the patient's response to Chiropractic treatment is immediate and phenomenal. In most cases there is more gradual, but quite satisfactory response to Chiropractic treatment. Occasionally, the results obtained from Chiropractic treatments are less beneficial to the patient that anticipated by both the Chiropractic Physicians and the patient. Two or more similar conditions my respond differently to the same Chiropractic care. May patients who do not respond to medical care find quick relief from their symptoms through Chiropractic treatment. Other conditions encountered by the patient respond better to medical care. The fact is that the science of Chiropractic and medicine my never be so exact as to provide definite answers to all health problems Both disciplines have made great strides in the diagnosis and treatment of health problems and will continue to improve the prognosis for patient care in the future.

The patient should discuss any questions or problems with the doctor before signing this statement of policy.

The undersigned acknowledges that he has read the forgoing statement and that he understands the nature of the care that he will receive from the Chiropractic Physician.

Dated as of X_____ X_____

Patient's Signature

IRREVOCABLE ASSIGNMENT, SECURITY AGREEMENT AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

I hereby authorize and direct you, (my insurance company, and/or my attorney), to pay directly to Andrew P. Azab, D.C.

(the "Provider") such sums as may be due and owing the Provider for health care services rendered me by reason of accident or illness. Further, I authorize and direct you to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Workers' Compensation benefits, or any other insurance benefits obligated to be paid to me or from any settlement or judgment on my behalf as may be necessary to adequately protect the financial interests of the Provider.

I hereby grant the Provider a security interest in any and all insurance benefits, and any and all proceeds of any settlement or judgment which may be payable to me as a result of the injuries or illness for which I have been treated by the Provider.

In the event my insurance company becomes obligated to make payments to me for charges for services rendered by the Provider and refuses to make such payments upon demand by the Provider or me, I hereby assign and transfer to the Provider any and all causes of action that I may have against such insurance company, and authorize the Provider to prosecute said cause of action either in my name or in the Provider's name. Further, I authorize the Provider to compromise, settle or otherwise resolve such claim or cause of action in such manner as the Provider shall determine in his sole discretion.

I understand that I remain personally responsible for the payment of all amounts due the Provider for health care services. I further understand and agree that this Assignment, Security Agreement and Authorization does not constitute consideration for the Provider to defer collection efforts for payment for health care services and the Provider may, at his option, demand immediate payment from me upon rendering such services.

I hereby authorize the Provider to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection of insurance benefits or the proceeds of any settlement or judgment under this Assignment, Security Agreement and Authorization.

I hereby appoint the Provider as my attorney-in-fact and agent to endorse/sign my name on any and all checks issued by the insurance company to me as payment of any accounts due and payable to the Provider for health care services.

I agree to pay the Provider for all costs of collection efforts, including court costs and attorneys fees, if the Provider must take any action to collect an outstanding balance on my account.

Dated: X _____ Patient's Signature: X _____

GENERAL RELEASE

Date: X _____ City and State: Lubbock, Texas

KNOW ALL MEN BY THESE PRESENTS: That I, X _____ authorize any doctor, hospital, employer, or other person, to whom a signed original or photocopy of this authorization is delivered, to furnish any information, copies of records, reports, and/or X-Rays which may be requested.

Patient's Signature: X _____

Date:_____

Dear _____Insurance Company

I hereby authorize and direct you, my insurance company, to release any and all information regarding my P.I.P/ Medical Payments Coverage including but not limited to claim limits and/or unused portion of those limits to Andrew P. Azab, D.C. dba All Family Chiropractic and Injury Clinic or their representative.

Signature: X_____

Printed Name: X_____

AUTHORIZATION

I do hereby authorize Andrew P. Azab, D.C. (the "Provider") to furnish you with a full report of his examination, diagnosis, treatment, prognosis, etc., of my physical condition following my involvement in an accident.

I hereby authorize and direct you to pay directly to the Provider such sums as may be due and owing the Provider for health care services rendered me by reason of such accident. Further, I authorize and direct you to withhold such sums from any settlement or judgment on my behalf as may be necessary to adequately protect the financial interests of the Provider.

I hereby grant the Provider a security interest in any and all proceeds of any settlement or judgment which may be payable to me as a result of the injuries for which I have been treated by the Provider.

I understand that I remain personally responsible for the payment of all amounts due the Provider for health care services. This Agreement is made solely to protect the Provider's financial interests in the proceeds of any settlement or judgment and in consideration of Provider waiting for payment for such health care services. I further understand that the payment to Provider is not contingent on any settlement or judgment through which I may eventually be paid for charges incurred for health care services.

Dated: X _____ Patient's Signature: X _____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all the terms of this Agreement and agrees to withhold such sums for any settlement or judgment as may be necessary to adequately protect the Provider's financial interests in the proceeds of such settlement or judgment.

Dated: _____ Attorney's Signature: _____

All Family Chiropractic & Injury Clinic
PATIENT CONSENT

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

X_____, 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.
    c. Telephoning my work and speaking to me. I understand that no messages will be left unless I have a personal voicemail.

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.

X_____ X_____
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: _____