Whole Health Partners
6211 West NorthWest Hwy.
Suite C-159
Dallas, Texas 75225
214-368-3030

PERSONAL HISTORY

LAST NAME	FIRST NAME	INITIAL	DATE

ADDRESS ______________________ SOCIAL SECURITY NUMBER ______________________

CITY, STATE, ZIP ______________________ INSURANCE CARRIER ______________________

HOME PHONE # ______________________ INSURANCE PHONE # ______________________

CELL PHONE # ______________________ INSURED'S NAME & DOB ______________ / ________

DOB _____ /_____ /_____ AGE _______ ❐ MALE ❐ FEMALE INSURED'S ID # ______________________

EMPLOYER NAME ______________________ GROUP # ______________________

WORK PHONE # ______________________ HOW DID YOU HEAR ABOUT US ______________________

❐ MARRIED ❐ SINGLE ❐ WIDOWED ❐ DIVORCED ❐ SEPARATED EMAIL ______________________

List your major area of pain and grade the intensity of pain. **Intensity**

1. ____ 0 1 2 3 4 5 6 7 8 9 10

2. ____ 0 1 2 3 4 5 6 7 8 9 10

3. ____ 0 1 2 3 4 5 6 7 8 9 10

4. Compared to a few months or years ago, my symptoms are the ❐ **Same** ❐ **Better** ❐ **Worse**?

5. Do you take pain pills, muscle relaxers, aspirin, or ibuprofen? ❐ **Yes** ❐ **No** If yes, ❐ **Daily** ❐ **Weekly**

6. What medications are you taking? ____

7. What vitamins are you taking? ____

8. Are you or could you be pregnant? ❐ **Yes** ❐ **No**

9. Do you have a pacemaker or another type of medical condition that we should know about?
❐ **Yes** ❐ **No** If yes please explain, ____

10. Who is you personal physician? ______________________________ Phone #__________________

11. What other Doctor have you seen for this condition? ______________________ Phone #__________________

Please put a "**C**" for any conditions you are **CURRENTLY** suffering from and a "**P**" for any conditions you have had in the **PAST** year.

____ Low Back Pain / Stiffness
____ Headaches
____ Neck Pain / Stiffness
____ Upper Back Pain
____ Mid-Back Pain / Stiffness
____ Poor Posture
____ Leg Pain / Sciatica
____ Carpal Tunnel / Wrist Pain
____ Muscle Tension

____ Spasms
____ Cramping
____ Numbness In Hands / Feet
____ Pain In Feet
____ Elbow Pain
____ Shoulder Pain
____ Hip Pain
____ Arm Pain
____ Arthritis

____ Knee Pain
____ Ear Ringing
____ Chest Pain
____ Sinus Problems
____ TMJ
____ Pain In Ribs
____ Trouble Sleeping
____ Weakness In Grip
____ Weakness In Legs

____ Stress / Tension / Irritable
____ Depression
____ Dizziness
____ Balance Problems
____ Allergies
____ Loss of Energy / Fatigue
____ Osteoporosis
____ Diabetes / Cancer
____ Overweight / Underweight

INSURANCE ASSIGNMENT AND CONSENT TO TREAT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Whole Health Partners 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 "Whole Health Partners" will be credited to my account upon receipt. **I clearly understand and agree that all services rendered me are charged directly to me and should the insurance company fail to pay, I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.**

I hereby authorize Whole Helath Partners to treat my condition as he/she deems appropriate. It is understood and agreed the amount paid to Whole Health Partners, for x-rays, is for examination only and the x-ray negatives will remin the property of this office, being on file where they may be seen at any time while a patient of this office. The Patient also agrees that he/she is responsible for all bills incurred at this office. Whole Health Partners will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

PATIENT'S SIGNATURE	CONSENT TO TREAT A MINOR	GUARDIAN OR SPOUSE'S SIGNATURE OF AUTHORIZING CARE
_____ /_____ /_____	_____ /_____ /_____	_____ /_____ /_____
DATE	DATE	DATE