WELCOME! To **Golightley Chiropractic** 2604 West Kansas Avenue Midland, Texas 79701 Ph: 432-262-6524

PATIENT INFORMATION

Date: _____

Patient Name: _____
Last Name First Name Middle Initial

Sex: ☐ M ☐ F Birthdate: _____-_____-_____ Social Security#_____

Address: _____

_____
City State Zip Code

Phone Number: _____ E-mail: _____

Emergency Contact Name: _____Phone #_____Relationship_____

Please circle: Married Widowed Single Separated Divorced
Minor Partnered for_____years

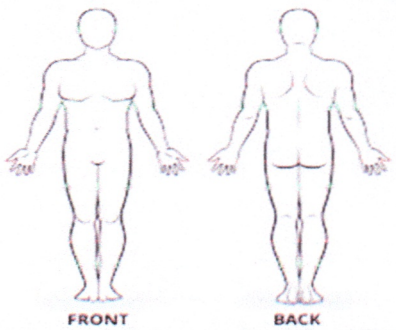
Patient Employer/School: _____Occupation: _____
Employer/School Address: _____Phone# _____

PATIENT CONDITION

Have you ever received chiropractic care? _____ If yes, when? _____
Chief compliant/Reason for visit_____
Complaint began when and how? _____
Is condition due to an accident? Circle: Yes No
If yes, when did this accident happen? _____ Type of accident: Auto Work Home
Is your condition progressively getting worse? _____
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Please circle the quality of the compliant/pain: Dull Aching Sharp
Shooting Burning Throbbing Deep Nagging Numbness
Tingling Stiffness Other: _____

How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your: Work Sleep Daily Routine Recreation
Please circle activities/movements that are painful to perform: Sitting Standing
Walking Bending Lying down
Does anything aggravate this pain? _____
Does anything make your compliant better? _____
Previous interventions, treatments, medications, surgery or care you've sought for you compliant:
_____
Previous illnesses you've had in your life: _____
Previous injury or trauma: _____

Mark an 'X' on the picture where you continue to have pain, numbness or tingling.



REFERRAL SOURCE

How did you hear about us?_____

HEALTH HISTORY

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes No	Chicken Pox	Yes No	Liver Disease	Yes No	Rheumatoid Arthritis	Yes No
Alcoholism	Yes No	Diabetes	Yes No	Measles	Yes No	Rheumatic Fever	Yes No
Allergy Shots	Yes No	Emphysema	Yes No	Migraine	Yes No	Headaches Scarlet Fever	Yes No
Anemia	Yes No	Epilepsy	Yes No	Miscarriage	Yes No	Stroke	Yes No
Anorexia	Yes No	Fractures	Yes No	Mononucleosis	Yes No	Suicide Attempt	Yes No
Appendicitis	Yes No	Glaucoma	Yes No	Multiple Sclerosis	Yes No	Thyroid Problems	Yes No
Arthritis	Yes No	Goiter	Yes No	Mumps	Yes No	Tonsillitis	Yes No
Asthma	Yes No	Gonorrhea	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Bleeding Disorders	Yes No	Gout	Yes No	Pacemaker	Yes No	Tumors, Growths	Yes No
Breast Lump	Yes No	Heart Disease	Yes No	Parkinson's Disease	Yes No	Typhoid Fever	Yes No
Bronchitis	Yes No	Hepatitis	Yes No	Pinched Nerve	Yes No	Ulcers	Yes No
Bulimia	Yes No	Hernia	Yes No	Pneumonia	Yes No	Vaginal Infections	Yes No
Cancer	Yes No	Herniated Disk	Yes No	Polio	Yes No	Venereal Disease	Yes No
Cataracts	Yes No	Herpes	Yes No	Prostate Problem	Yes No	Whooping Cough	Yes No
Chemical Dependency	Yes No	High Cholesterol	Yes No	Prosthesis	Yes No	Other	Yes No
		Kidney Disease	Yes No	Psychiatric Care	Yes No		

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ HeavyLabor

Habits

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are You pregnant? ☐Yes ☐No Due Date _____ What was the date of your last menstrual period? _____

Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death — Age at death

_____ _____

_____ _____

_____ _____

Social and Occupational History:

A. Level of Education:

☐ High school ☐ some college ☐ college graduate ☐ post graduate studies

B. Job Description: _____ Work Schedule: _____

C. Recreational Activities: _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS — ALLERGIES — VITAMINS/HERBS/MINERALS

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy Name _____ _____ _____

Pharmacy Phone (____) _____ _____ _____

Golightley Chiropractic

2604 W. Kansas Ave. Midland, TX 79701

Ph: (432) 262-6524 Fax: (432)262-6538

For All Your Health & Wellness Needs

Office Policy

Welcome to Golightley Chiropractic & Wellness Center. This is an appointment practice. For all appointments we ask that you call and notify the receptionist if you are running late for an appointment. **If you do not show for a scheduled appointment our office may charge a $25.00 cancellation fee. Although we rarely do charge a "No Show" fee, if a patient repeatedly cancels without notice we may require this fee. If you will be more than fifteen minutes late there is a possibility that we will have to reschedule your appointment. We do not file insurance.** Our office reserves the right to request payment for services from you. We will provide you an itemized statement upon request for you to file your insurance claim if you choose to do so.

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by Dr. Golightley, D.C. and other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above. I hereby authorize Dr. Golightley to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed.

I understand that the doctor will not accept individuals for treatment unless he can be of assistance. It is understood and agreed that any x-ray negatives taken by Golightley Chiropractic will remain the property of this office, being on hand where they may be seen at any tine while being as patient of this office. I have had an opportunity to discuss with the doctor of chiropractic named above and/or office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature_____**Date**_____

Guardian/Parent Signature_____**Date**_____

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For All Your Health & Wellness Needs

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Golightley Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
You may review the notice prior to signing consent. You may request a copy of the notice at the front desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. This office may or may not agree to restrict the use or disclosure of your protected health information.
If we agree to your request, the restriction will be binding with this office. Use or disclose of protected information of an agreed restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that's has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

'I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.'

Name of Patient (PRINT)

Signature of Patient Date

Signature of Patient Representative Date

Relationship of Patient Representative to Patient

Office Representative Date

Others we may release your PHI to: