Gonino Center for Healing
Gonino Wellness Chiropractic
6720 Horizon Road, Heath, TX 75032
Phone: 469-402-2800 Fax: 469-402-0348

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Personal History

Today's Date: _______/_______/_______

Patient Name (print):______________________________ Age____ Case Number__________
Address:______________________________ City:______________ State:________ Zip:__________
Home#:__________________ Cell:__________________ Work:__________________
Email:__________________ Driver's License #:__________________ SS#:__________________
D.O.B:_____/_____/_____ Referred By:______________________________
Marital Status:__________________ Spouse's Name:__________________
Emergency Contact:______________________________ Contact#:__________________
Relationship:______________________________
Occupation:______________________________ Employer:__________________
Insurance Company:__________________ Policy #:__________________ Group#:__________

Personal Health History

Past Chiropractic Care?______________________________
If Yes, When?______________________________ Where?__________________

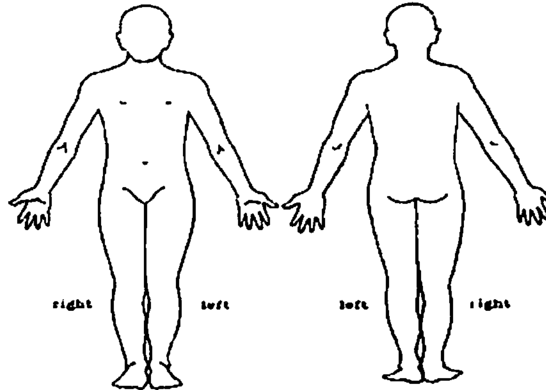
0 - NO PAIN
10 - INTENSE PAIN

Example ______Neck______
0 1 2 3 4 5 6 7 8 9 10

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



Present Complaint:______________________________

Pain/Problem started on: ______________________ Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

1. What activities aggravate your condition/pain? ______________________________
2. What activities lessen your condition/pain?______________________________
3. Is this condition/pain worse during certain times of the day? ☐ Morning ☐ Afternoon ☐ Evening
4. Is this condition/pain interfering with life? ☐ Work ☐ Sleep ☐ Routine ☐ Other ____________
5. Is this condition getting progressively worse? ☐ If No, please check. If yes, please explain.______________________________

____
6. Have you seen anyone regarding this condition? ☐ If No, please check. If yes, please list.______________________
7. Have you been under drug and medical care? ☐ If No, please check. If yes, please explain.______________________
8. What medication(s) are you currently taking? ☐ If None, please check.______________________
9. Have you had surgery? ☐ Yes ☐ No

10. What side effects have you experienced from surgery? ☐ If None, please check.

11. Is there a family history of?

Father's Side: ☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: ____________________

Mother's Side: ☐ Heart Disease ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Other: ____________________

Symptoms

☐ Headaches	☐ Dizziness	☐ Fatigue	☐ Loss of Smell
☐ Neck Pain	☐ Face Flushed	☐ Depression	☐ Loss of Taste
☐ Sleeping Problems	☐ Neck Stiff	☐ Light Bothers Eyes	☐ Diarrhea
☐ Back Pain	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Feet Cold
☐ Nervousness	☐ Pins & Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Tension	☐ Numbness in Fingers	☐ Fever	☐ Stomach Upset
☐ Irritability	☐ Numbness in Toes	☐ Fainting	☐ Constipation
☐ Chest Pains	☐ Shortness of Breath	☐ Cold Sweats	☐ Loss of Balance

1. Was Your Birth Traumatic?	Patient	Chiropractor's Comments
Long Delivery	Y	
Difficult Delivery	Y	
Forceps	Y	
Caesarian	Y	
Breach/Cephalic	Y	
Home Birth	Y	
Mother given drugs during delivery	Y	
Induced Labor	Y	

3. Growth and Development	Patient	Chiropractor's Comments
Fall out of Bed	Y	
Bang your head	Y	
Breastfed	Y	
Childhood Illness	Y	
Have any Accidents	Y	
Have Surgery	Y	
Take Drugs	Y	
Fall while learning to walk	Y	
Bullied by your siblings	Y	
Child Abuse	Y	
Chair pulled out while sitting	Y	
Fall down the stairs	Y	
Pulled by your arm	Y	
Experience other traumas	Y	

3. Current Health Habits	Patient	Chiropractor's Comments
Smoke	Y	
Drink	Y	
Diet (Do you eat healthy foods)	Y	
Have you been in accidents	Y	
Drugs (Prescribed or Non-Prescribed	Y	
Have Teeth Problems	Y	
Have Eye Problems	Y	
Have Hearing Problems	Y	
Exercise Regularly	Y	
Have Sleeping Problems (Nightmares)	Y	
Have Occupational Stress	Y	
Have Physical Stress	Y	
Have Mental Stress	Y	
Have Hobbies/Sports Injuries	Y	
Sleeping Posture (Side/Stomach/Back)	Y	

4. Operations and Procedures	Date
Vaccinations	
Tonsillectomy	
Gall Bladder	
Back Operation	
Tubes in Ears	
Appendectomy	
Female Organs	
Rectal Surgery	
Sinus	
Hernia	
Thyroid	
Stomach	
Other:	

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of treatment plans Andrea Heikkinen would like for you to receive. Chiropractic Treatment Plans are designed to help get you feeling better quickly and to help you be as healthy as possible. Please review the explanations of the Chiropractic Treatment Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to:

☐ Feel better quickly
☐ Have a healthier spine
☐ Have a healthier body by keeping my nerve system healthy
☐ Live a healthier lifestyle

____________________________________ ____________________

Signature of Patient and/or Legal Guardian **Date**

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ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for serviced rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to dispense a separate draft to pay in full all services rendered payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the facility/physician named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case. A photocopy of this instrument will serve as the original.

____

Patient's Printed Name

______________________________	______________________________	_______________
Signature of Patient or Responsible Party	Signature of Witness	Date
______________________________	______________________________	____/____/____
Responsible Party Printed Name	Social Security Number	Date of Birth

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Informed Consent

We want your Chiropractic experience to be excellent. We are available to discuss with you the risks and benefits of the chiropractic adjustment and any treatments that we provide in our office. Our office offers treatments such as physical examinations, chiropractic adjustments by hand or with an instrument, myofascial release, energy balancing, electrical muscle stimulation, ultrasound, moist heat and ice pack treatment, lymphatic pump and Chi machine. These services and treatments can possibly create soreness, bruising and minor injuries in some patients. Our office will do our best to evaluate you for any risks you may have due to these treatments and will explain them individually. There are some risks to chiropractic adjustments such as bone fracture to weakened areas and bruising or strains to unhealthy muscles. There is a small percentage of the population that is at risk of stroke from chiropractic treatments. If Dr. Andrea finds that you are potentially at risk, she will offer you an alternative type of treatment. People of all ages can safely be adjusted with care and proper evaluation. I understand the risks that have been explained and consent to chiropractic examination and treatment under the direction of Andrea Heikkinen, DC.

____

Signature of Patient or Personal Representative

____ __________________

Patient's Printed Name Date

Acknowledgement of receipt of Notice of Privacy Practices

By signing, I acknowledge that this office has provided a copy of the Notice of Privacy Practices and I have read it or it has been read to me. I understand that my patient records are confidential and will be respectively protected unless this office is given written permission from me to release specific information.

____

Signature of Patient or Personal Representative

____ __________________

Patient's Printed Name Date

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Patient Communication

May we contact you or send detailed messages related to your treatment/appointments by:

Yes No Home Phone
Yes No Work Phone
Yes No Cell Phone
Yes No Mail
Yes No E-mail at Home E-mail Address________________________
Yes No E-mail at Work E-mail Address________________________

May we send postcard communications such as scheduling reminders, thank-you cards, sympathy cards, birthday cards, or holiday cards?

Yes No Home
Yes No Work

May we send you a periodic newsletter?

Yes No E-mail
Yes No Mail

May we discuss your treatment and/or appointment times with a spouse, parent or friend?
(Please List names below)

____

____

____

____
Signature of Patient or Personal Representative

____ ____________________
Patient's Printed Name Date