ATLAS MEDICAL CENTER

Dr. Jason Kouri, MD
Lisa Moore, ANP
Dr. Robert Hanson, DC
Dr. Alexandra Schnee, DC

Confidential Patient Health Record

Please do not leave any question blank.

Date_____ **Sex:** _____F _____M **Height**: _____ **Weight**: _____lbs

Last Name: _____ **First Name**: _____ **MI**: _____

Date of Birth: _____ **Age**: _____ **Social Security #:** _____

Address: _____

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

Home #: _____ **Cell #**: _____ **Work #**: _____

E-mail:_____
Can we email you? Yes / No

Best way to reach you: Home / Work / Cell -- *Can we leave a message?* Yes / No
**If we can leave a message on your cell phone, what is your cell carrier? AT&T / Verizon / T-Mobile / Other: _____

Would you like to receive a text message for appointment reminders? Yes/ No

WORKING STATUS

□ Full Duty □ Light Duty □ Off Duty per Dr. □ Employed □ Unemployed □ Retired

Occupation: _____ **Employer:** _____

Primary Care Doctor: _____
Do we have your permission to contact your doctor regarding care in our office? Yes / No

Marital Status: Married / Single / Widowed / Divorced

Emergency Contact: _____ **Phone #:**_____

Preferred Language: English / Spanish / Other: _____

CMS requires providers to report both race and ethnicity
Race: American Indian or Alaskan Native / Asian / African American / Native Hawaiian or Other Pacific Islander / Caucasian / Decline to Specify

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline to Specify

How did you hear about this program and/or the Doctor(s)? *(Please check one)*

Referred by:
□ My doctor
□ Dallas Morning News
□ Google
□ Friend
□ T.V.
□ Former pt.: _____
□ Star Telegram
□ Other _____

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Signature: _____ Date: _____
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PRIMARY COMPLAINTS: *Sample complaints: Low Back, Left Knee, Right Shoulder, Neck, etc.*

	1st Complaint	2nd Complaint	3rd Complaint	4th Complaint
Write in your complaint(s) in order of importance. → →	**1.**	**2.**	**3.**	**4.**
Circle the word(s) that best describe the complaint.	Sharp - dull - achy throbbing - numb shooting - burning tingling - other	Sharp - dull - achy throbbing - numb shooting - burning tingling - other	Sharp - dull - achy throbbing - numb shooting - burning tingling - other	Sharp - dull - achy throbbing - numb shooting - burning tingling - other
How often do you feel this complaint?	Constant / Daily / Weekly / "Off and On"	Constant / Daily / Weekly / "Off and On"	Constant / Daily / Weekly / "Off and On"	Constant / Daily / Weekly / "Off and On"
How long have you had this complaint?	#_____ Days / Weeks / Months / Years	#_____ Days / Weeks / Months / Years	#_____ Days / Weeks / Months / Years	#_____ Days / Weeks / Months / Years
Is it getting better, worse, or staying the same?	Better – Worse – Same	Better – Worse – Same	Better – Worse – Same	Better – Worse – Same
What makes it better, if anything?	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____	Nothing - Activity – Standing – Exercise – Sitting – Rest - Other_____
What makes it worse, if anything?	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position	Walking – Standing – Sitting – Playing sports – Weather changes – Heat – Cold – Lying down – Getting up from seated position
On a scale of 0 – 10, rate your discomfort. *(0 = no pain, 10 = excruciating)*	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10	**Circle response** 0 1 2 3 4 5 6 7 8 9 10
How have you taken care of this in the past? Has that worked for you?				
Circle the ways this issue is affecting your life? *(all that apply)*	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity	Job children sex marriage household hobbies finances sports exercise walking standing bowels urinary fatigue loss of sleep moody poor attitude loss of productivity
Improving this issue in my life would improve my quality of life by: *(Circle best response)*	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%	10-20% 30-40% 50-60% 70-80% 90% 100%

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1.) Is your main condition from an: □ Auto Accident Injury □ Job Injury □ Other: _____

How did your injury/condition occur? Was it sudden or a gradual occurrence? _____

2.) What have you tried at home to relieve the pain in the last 6 months? Check all that apply:

□ Tylenol □ NSAIDS/Ibuprofen □ Aspirin □ Heat □ Brace
□ Supplements □ Pain-relieving creams □ Stretches □ Ice pack
□ Exercise □ Other: _____

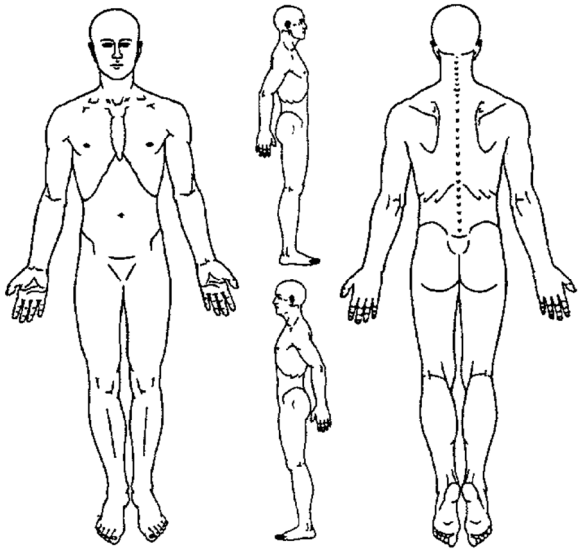
3.) Have you tried any of the following? Check all that apply:

□ Massage □ Surgery □ Cortisone Injections - How long ago? _____
□ Narcotics □ Metanx □ Manipulations - How long ago? _____
□ Celebrex □ Neurontin □ Occupational therapy - How long ago? _____
□ Lyrica □ Home Exercises □ Physical therapy/Rehab - How long ago? _____
□ Tramadol □ Topical □ Epidurals - How long ago? _____
□ Cymbalta □ Injections Series (*Euflexxa*/*Hyalgan*)/Viscosupplementation for knees - How long ago? _____

Patient Health History

Please check if you are currently experiencing any of the following conditions and then circle problematic areas on body on the right:

□ Neck Pain/Stiffness □ Nausea □ Pins/Needles in Arms
□ Back Pain/Stiffness □ Night pain □ Pins/Needles in Legs
□ Arm/Hand Pain □ Fatigue □ Light Bothers Eyes
□ Leg/Knee Pain □ Fever □ Recent Weight Change
□ Headaches □ Tension □ Loss of Memory
□ Loss of Taste □ Chest Pain □ Cold Extremities
□ Nervousness □ Asthma □ Sleeping Difficulties
□ Jaw Problems □ Cold Sweats □ Bowel/Bladder Changes
□ Dizziness/Fainting □ Loss of Smell □ Constipation/Diarrhea
□ Blurred/Double Vision □ Swollen Joints □ Loss of Balance
□ Mood Changes □ Foot Trouble □ Trouble Concentrating
□ Other: _____



4.) When was the last time you have seen a doctor for your condition(s)?

_____

Name of the doctor(s): _____

Surgical History:

5.) List ANY surgeries and/or hospitalizations that you have had including their corresponding dates. □ NONE

_____

_____

6.) Please indicate which diagnostic tests you have had in the <u>past year</u> relating to your complaints:

□ X-ray □ EMG/NCV
□ CT Scan □ MRI
□ Discogram □ None

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7.) List any and all medications you are currently taking including over the counter and supplements:

MEDICATIONS	DOSE: (MG, MCG)	TIMES PER DAY	HOW LONG?
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			

PAST MEDICAL HISTORY

8.) Have you had any of the following? – Check all that apply:

		COMMENTS			COMMENTS
Bowel Disorders			**Polio**		
Cancer (Where)			**Psoriasis**		
Depression			**Rheumatism**		
Diabetes			**Seizures**		
Heart Disease			**Serious Infection**		
High Blood Pressure			**Stroke**		
Kidney Disease			**Surgery**		
Liver Disease			**Thyroid**		
Multiple Myeloma			**Other**		
Pacemaker			**NONE**		

9.) Do you use tobacco? Yes / No If **yes**, how often do you smoke? _____
Age/year started? _____ Year quit? _____

10.) Do you consume alcohol? Yes / No **Frequency? _____**

11.) What is your daily intake of caffeine? *(Coffee, soda, tea, ect.)* **_____**cups per day

12.) Do your work/daily activities mainly involve: □ Sitting □ Standing □ Light labor □ Heavy labor

13.) Do you exercise? □ Unable due to condition □ Everyday □ Occasionally □ None

14.) ARE YOU ALLERGIC TO ANY MEDICATIONS?: □ Yes □ No **If yes, list below:**

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

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LATEX ALLERGIES?: □ Yes □ No

FOOD / ENVIRONMENTAL ALLERGIES?: □ Yes □ No **If yes, list below:**

1.	Reaction:
2.	Reaction:
3.	Reaction:
4.	Reaction:

Review of Systems:

Please check if you've experienced any of the following:

CONSTITUTIONAL

Chills___ Depression____ Dizziness___ Fainting___ Fever___ Night Sweats__ Loss of Sleep___ Allergy_____ (to what_____) Weight gain in the past six months_____ Weight loss in the last six months_____ Nervousness_____ Other_____ NONE_____

DISEASES/CONDITIONS

Appendicitis____ Anemia____ Arthritis____ Alcoholism____ Abdominal Surgery____ Bleeding Disorder_____ Blood Clot(s) _____ Breathing Difficulty_____ High Cholesterol_____ Colon Problems_____ Epilepsy____ Eczema____ Eating Disorder____ Glaucoma____ HIV+____ Hernia____ Headaches____ Hormone/Gland Problems___ Influenza____ Low Back Pain____ Mental Illness____ Parkinson's Disease___ Hyperthyroid____ Hypothyroid____ Rectal Surgery____ Tuberculosis_____ Other_____ NONE_____

CARDIOVASCULAR

Chest Pain_____ High Blood Pressure_____ Low Blood Pressure_____ Poor Circulation____ Rapid Heartbeat_____ Previous Heart Problem_____ (describe_____) Slow Heartbeat_____ TIA_____ Swollen Ankles___ Varicose Veins____ Aortic Aneurysm_____ Bruise easily_____ Heart Murmur____ Palpitations_____ Pacemaker_____ Other_____ NONE_____

EARS/EYES/NOSE/THROAT

Deafness_____ Recent Changes in Hearing_____ Ear Pain_____ Nose Bleeds___ Sinus Problems___ Sore Throat___ Recent Changes in Smell_____ Recent Change in Vision_____ Recent Changes in Taste__ Other_____ NONE_____

GASTRO-INTESTINAL

Gas_____ Colon Trouble____ Constipation_____ Diarrhea____ Gallbladder Trouble___ Hemorrhoids___ Liver Trouble___ Nausea___ Stomach Ache____ Poor Appetite____ Poor Digestion_____ Vomiting_____ Vomiting Blood____ Rectal Bleeding___ Bloating___ Other_____ NONE_____

GENITO-URINARY

Blood in Urine___ Frequent Urination___ Inability to control urine___ Kidney Infection___ Painful urination___ Prostate Trouble___ Urinary Tract Infection_____ Other_____ NONE_____

FOR MEN ONLY

History of Prostatitis___ Difficulty Urinating___ Other_____ NONE_____

FOR WOMEN ONLY

Menstrual Cramps____ Excessive Menstrual flow___ Hot Flashes___ Irregular Cycle___ Painful Periods___
Birth Control Pills___ Abnormal Pap Smear___ Other_____ NONE_____

MUSCLE/JOINT/BONE

Back Pain/Stiffness___ Leg/Knee Pain___ Arm/Hand Pain___ Foot Trouble___ Hip Pain___ Shoulder Pain/Stiffness__
Pain between Shoulders___ Painful Tailbone___ Neck Pain/Stiffness___ Spinal Curvature___ Cramps___
Attack of Weakness____ Morning Stiffness_____ Joint pain/Swelling____ Other_____ NONE_____

NEUROLOGIC

Convulsions___ Seizures____ Dizziness____ Hand Trembling____ Weakness____ Loss of Memory____
Difficulty with speech___ Loss of coordination/Balance___ Poor appetite____ Numbness/Tingling Feet___
Numbness/Tingling Hands___ Pins/Needles in Arms____ Pins/Needles in Legs____ Cold Extremities___
Other_____ NONE_____

RESPIRATORY

Asthma_____ Chest Pain____ Chronic Cough____ Bronchitis___ Difficulty Breathing____
Coughing/Spitting Blood____ Wheezing____ Allergy Shots____ Other_____ NONE_____

FAMILY HISTORY: Has any member of your family (including parents, grandparents, and siblings) been diagnosed with any of the following diseases?
Diabetes_____ Kidney_____ Arthritis_____
Heart Disease_____ Cancer_____ Lung_____ NONE_____

Any additional comments that may help the doctor understand your condition?
_____
_____
_____

I hereby authorize the Doctor/provider to treat my condition as he or she deems appropriate. The doctor will not be held accountable for any pre-existing medically diagnosed condition nor for any medical diagnosis. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I certify that the above information is true and correct. I understand that providing incorrect information can be dangerous to my health. I will give complete and accurate information during my exam.

_____	_____	_____
Patient's Signature	**Printed Name**	**Date**
_____	_____	_____
Consent to Treat a Minor Guardian's Signature	Printed Name	Date
_____	_____	_____
Guardian of Spouse's Signature for Authorizing Care	Printed Name	Date

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ATLAS MEDICAL CENTER

3401 W. Airport Frwy. Ste. 101
Irving, TX 75062
P: 214-596-1051
F: 214-596-1052

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinic will attempt to identify any ailments you may have that may be corrected through physical medicine, massage therapy, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific things which otherwise might not come to the attention of the physician (deformities, illnesses, etc.).

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they can be borrowed by the patient.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

X-Ray Questionnaire: For women only Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your conditions. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period: _____

☐ There is a possibility that I may be pregnant at this time ☐ Yes I am definitely pregnant

☐ No, I am definitely not pregnant at this time ☐ I request that x-ray films not be taken because:

_____ _____
Patient's Signature Date

FOR MINORS: I, _____ being the parent of legal guardian of _____,
(Print Guardian Name) (Print Minor's Name)
have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

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INSURANCE BENEFITS

As a courtesy, our Facility will obtain a verification of applicable insurance benefits. We provide you information about your insurance as it is quoted to us; however, we cannot be held liable or responsible for any misinformation quoted to us by your insurance company. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an insurance company, liable or third party payer are between you and said person.

Furthermore, I understand that our facility and staff 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 our facility will be credited to my account on receipt.

If you would like us to verify your insurance benefits please provide this office with a copy of your insurance card(s).

Assignment and Release:

I certify that (or my dependent) have insurance coverage with _____ and I authorize, request and assign my insurance company to pay directly to the Texas Physicians Specialized Medicine PLLC/ DBA Atlas Medical Center insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/provider to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

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

Print Name: _____

Signature: _____ Date: _____