PHYSICAL MEDICINE
ALLSTAR HEALTHCARE
7180 Bandera Rd. San Antonio, TX 78238

Name:_____
Date:_____

Health Questionnaire

Name:_____DOB:_____SocialSecurity #:_____

Home/Cell #_____Work#_____

Address:_____City:_____State:_____Zip Code:_____

Email:_____Occupation:_____Hrs Worked:_____

EmergencyContact:_____Phone #:_____Relation:_____

How did you hear about us?_____

Please check any of the following you've experienced in the past 6 MONTHS:

- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Fibromyalgia
- ☐ Pain in Legs
- ☐ Pain in Knees
- ☐ Other (please explain):
- ☐ Tension Across Top of Shoulders
- ☐ Pain Between Shoulder Blades
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in Feet
- ☐ Neuropathy
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Carpal Tunnel
- ☐ Headaches

Which of the above is worst?_____

How long have you experienced these symptoms?_____

What does it feel like? (please explain):_____

What have you done that has helped this problem?_____

What activities would you like to do if this was not a problem?_____

What does this cause you to be?

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt Sleep
- ☐ Restrict your daily activity
- ☐ Pain in Legs

Does this affect your work?

- ☐ Decision Making
- ☐ Poor Attitude
- ☐ Decreased productivity
- ☐ Exhausted at end of the day
- ☐ Unable to work longer hours

Does this affect your life?

- ☐ Lose patience with family
- ☐ Restricted household duties
- ☐ Hinders Exercise/Sports
- ☐ Interferes with the ability to do hobbies Or other activities

What have you tried to help relieve/get rid of this problem and how much did it help (please explain):

	N/A	Did NOT help	Helped a Little	Helped Some	Helped A Lot
Medications					
Physical Therapy					
Chiropractic					
Exercise					
Nutrition					
Other (explain)					

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment, or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the healthcare providers and/or clinic from any damage resulting from this demonstration.

_____ _____

Signature Date

PHYSICAL MEDICINE ALLSTAR HEALTHCARE

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Name:_____
Date:_____

Review of Systems

CONSTITUTIONAL			NEUROLOGICAL			
☐ Weight Loss	☐ Weight Gain		☐ Headaches	☐ Paralysis	☐ Seizure	☐ Tingling
☐ Night Sweats	☐ Fever/Chills		☐ Tremors	☐ Fainting spells	☐Memory Loss	
			☐ Change in sensation anywhere in your body			
EARS, EYES, NOSE & THROAT			**CARDIOVASCULAR**			
☐ Ear Infections	☐ Hearing Loss	☐ Ringing in ears	☐ Leg Cramps	☐ Ankle Swelling	☐ Cold hands/feet	
☐ Eye Problems	☐ Glasses/Contacts	☐ Glaucoma	☐ High Blood Pressure	☐ Heart Attacks	☐ Blood Clots	
☐ Cataracts	☐ Double Vision	☐ Nosebleeds	☐ Dizziness when standing too quickly		☐ Varicose Veins	
☐ Sinus Infections	☐ Allergies	☐ Swollen Glands	☐ Leg pain that resolves with rest			
☐ Hoarseness	☐ Gum Problems	☐ Problems Swallowing				
RESPIRATORY			**SKIN**			
☐ Asthma	☐ Prolonged cough	☐ Emphysema	☐ Abscess	☐ Rashes	☐ Lumps	
☐ Shortness of Breath	☐ Tuberculosis	☐ Wheezing	☐ Dryness	☐ Sores	☐ Irregular Moles	
			☐ Color Changes in Hair or Nails			
MUSCULOSKELETAL			**ENDOCRINE**			
☐ Anemia	☐ Arthritis	☐ Bursitis	☐ Diabetes	☐ Borderline Diabetes	☐ Cold Intolerance	
☐ Gout	☐ Joint Aches	☐ Joint Swelling	☐ Heat Intolerance	☐ Excessive Thirst	☐ Excessive Sweating	
☐ Morning Stiffness	☐ Muscle Aches	☐ Neck Aches	☐ Excessive Hunger			
☐ Back Aches						
GASTROINTESTINAL			**PSYCHOLOGICAL**			
☐ Diarrhea	☐ Constipation	☐ Ulcers	☐ Feelings or History of Depression		☐ Anxiety	
☐ Hepatitis	☐ Nausea	☐ Hemorrhoids	☐ Suicidal Thoughts	☐ Mood Changes	☐Nervousness/Tension	
☐ Vomiting	☐Heartburn/Indigestion	☐ Abdominal Pain				

Not Listed Above:_____

_____ _____

I the above signed affirm the above is true (patient signature) Date

Physician's Comments:

PHYSICAL MEDICINE ALLSTAR HEALTHCARE

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Name:_____
Date:_____

PAST MEDICAL: Check (✓) if you have ever been diagnosed with any of the following:

☐ Cancer ☐ Thyroid Condition ☐ Fibromyalgia ☐ Gout ☐ HIV/AIDS/Autoimmune Disorder

☐ Other:

MEDICAL: Check (✓) any treatments you are CURRENTLY receiving from another Healthcare Provider

☐ Chemotherapy/Radiation Therapy	☐ Physical Therapy	☐ Chiropractic	☐ Injections	☐ Dialysis
☐ Pain Management	☐ Other:			

SURGICAL : Check (✓) if you have ever had any of the following surgeries:

☐ Head/Brain	☐ Upper Extremity	☐ Internal Organs	☐ Throat	☐ Neck	☐ Lower Extremity
☐ Eyes	☐ Back	☐ Heart Bypass	☐ Ears	☐ Spine	☐ Nose
☐ Pacemaker/Defibrilator		☐ Other:			

ALLERGIES Check (✓)

☐ Latex	☐ Chicken	☐ Milk	☐ Eggs	☐ Penicillin	☐ -Cain Medications
☐ Other: (Please List)					

FAMILY: Check (✓) any that apply to you:

	YOU	Biological Mother	Biological Father	Sib #1 M/F	Sib #2 M/F	Sib #3 M/F	Sib #4 M/F
Alive							
Cancer							
Heart Problems							
Alzheimer's/ Dementia							
Lupus							
Diabetes							
Asthma							
Psychological							
Other							

SOCIAL Check (✓) any that apply to you:

	Smoker _____pks/day ____years		Illicit/Street/Recreational Drugs		Employment
	Quit Smoking				
	Alcohol _____ drinks/week		Retired		Hobbies

Please list any medications and/or vitamins/supplements you currently take:

Name of medication	What is it for?	How much do you take?	How long have you taken it?	Who prescribed it?

Positive and pertinent findings of the above PMFSH were reviewed and addressed by the physician at time if Initial Exam.

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Name:_____
Date:_____

PLEASE FILL THIS PAGE OUT COMPLETELY AND TO THE BEST OF YOUR KNOWLEDGE

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
3. Do your hands or arms fall asleep regularly? NO YES
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
5. Do you suffer from a loss of handgrip strength? NO YES
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
8. Do your legs or feet fall asleep regularly? NO YES
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
10. Do you suffer from cold hands or feet? NO YES
11. Do you have frequent falls or find that you trip over your feet while walking? NO YES
12. Do you suffer from frequent headaches? If yes, how often? NO YES
13. Have you ever been diagnosed by any physician with having peripheral neuropathy? NO YES
    If yes, when and what treatment has been tried?
14. Have you tried any medications for your pain such as anti-inflammatory? NO YES
    If yes, what kind of medication? (Aleve, Mortrin, Tylenol, steroids, flexeril)? _____
15. Have you had an MRI? NO YES
    If yes, when? Who ordered it? Why was it ordered? _____
16. Have you used any splint or braces or other prescribed treatment by an MD? NO YES
    If yes: When? What kind? Who Ordered it? _____

ALLERGY QUESTIONNAIRE

1. How long have you had Nasal, Sinus, Chest and skin symptoms listed on prior page?
   Nasal: Sinus: Chest: Skin:
2. How often do the symptoms occur? (constant, daily, weekly, monthly, off and on)
   Nasal: Sinus Chest Skin
3. Is there any seasonal variation in your symptoms and if so, when are they worse? NO YES
   Nasal: Sinus Chest Skin
4. What medications have you tried for your allergy symptoms? Circle the ones that have helped/ _____

YOUR ENVIRONMENT

1. What environmental triggers have made your symptoms worse? Please circle:

Mowed grass	Windy weather	Dust	Spending time outdoors	Moldy Places
Sweeping	Dusting	Cigarette Smoke	Pollen	Insect Sting
Exercise	Respiratory Infection	Cold Air	Weather changes	Laughing
Nighttime	Stressful events	Animals (specify)		Perfumes
Cosmetics	Odors, etc. (specify)			

2. How long have you lived in this area? _____ Where else have you lived? _____
3. Are you better or worse in this area? BETTER WORSE Any smokers at home? YES NO
4. Do you have any pets? If so, please list: _____
5. Are symptoms worse around your pet? YES NO Any previous pets in the home? YES NO
6. Type of home: APARTMENT/CONDO HOUSE Has your home had water/flood damage? YES NO
7. What kind of work do you do? _____ Are symptoms worse at work? YES NO
8. Have you traveled out of the country in the past year? If so, where? _____
9. Are there other households you visit frequently? YES NO Explain: _____

PREVIOUS ALLERGY TREATMENT

1. Other doctors seen for allergies? ENT Allergist Pulmonologist Dermatologist Gastroenterologist
2. Have you had nasal or sinus surgery? If so, when and where?
3. Have you treated for this in Urgent Care or the ER with asthma? If so, when?
4. Have you had allergy test? When and Where? Allergy Shots? When? Where?
5. Is there anything else you would like to share about your allergies? _____
6. If you could fix one thing about your allergies what would it be? _____

Positive and pertinent findings of the above ROS were reviewed and addressed by the physician at time if Initial Exam.

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INFORMED CONSENT

The focus of today is to find out what your complaints are through a "talk with the doc". If further testing, evaluations, and/or treatments are needed, you will be notified of the cost prior to having them performed. It is important that each patient understands both the objective of their treatment and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo care after being advised of the known medical benefits, risks and alternatives.

Allstar Healthcare Physical Medicine offers Chiropractic as one of our non-invasive treatment options. Chiropractic is an art and a science which concerns itself with the relationship between the structure (spine) and function (nervous system) as that relationship may affect the preservation and restoration of health. An adjustment is the specific application of forces to correct and reduce spinal misalignments and may be done by hand or by hand held instruments. Chiropractic care, like all forms of healthcare, offers considerable benefit, but may also include some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of disc condition, and rarely fractures of vertebral artery injury/stroke. Chiropractic adjustments are typically performed in an open area, however private rooms are available upon request. Please inform the Chiropractor prior to your treatment if you prefer a closed room. Any conversations regarding your personal and protected health information are performed in private rooms for your protection.

During your course of care, we will inform you of any medical and/or chiropractic findings we encounter, and our medical team will recommend a plan of care. Signing this form demonstrates your acknowledgement that all questions regarding the doctors' objectives pertaining to your care in this office have been answered, and that the benefits, risks, and alternatives of both medical and Chiropractic care have been explained to you to your complete satisfaction. Signing below also gives the doctors of Allstar Healthcare permission to use your name, testimonials, pictures, x-rays, and case history information for advertisements and/or educational reports or in any way he/she desires for an unlimited time from this way forward.

Patient Consent for Use and Disclosure of Protected Health Information:

With my consent, Allstar Healthcare Physical Medicine (ASHC) may use and disclose protected health information (PHI) about me to carry out treatment and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. I acknowledge that I have reviewed the Notice of Privacy Practices of ASHC and that it is the policy of this office to leave a message on voicemail, in person in reference to any items that assist in the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others. With my consent, ASHC may mail or e-mail to my home or other designated location any items that assist in the practice of carrying out TPO, including, but not limited to appointment reminder cards and patient statements. I may make a request of an alternative means of communication (within reason) in writing. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I hereby acknowledge receipt of ASHC's Notice of Privacy Practices with respect to the patient. At any time, I have the right to review the Notice of Privacy Practices that may be obtained by forwarding a written request to ASHC's Privacy Officer at 7042 Bandera Road, San Antonio, TX 78238. By signing this form, I am consenting to ASHC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ASHC may decline to provide treatment to me.!

Consent to Evaluate and Adjust a Minor

I, being the parent or legal guardian of this child, have read and fully understand the above informed consent and Privacy Notice and hereby grant permission for my child to receive care at this office.

_____ _____

Child's printed name Legal Guardian (Signature)

FEMALES ONLY: Pregnancy/X-ray Release

Radiation from x-rays can be harmful to an unborn child. Please sign below to certify that to the best of your knowledge you are **not pregnant**. The doctors and their associates at Allstar Healthcare have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to my unborn child.

_____

Signature

_____ _____

Signature Date

PHYSICAL MEDICINE ALLSTAR HEALTHCARE

7180 Bandera Rd. San Antonio, TX 78238

Name:_____
Date:_____

Constitutional
- □ Deny All
- □ Chills
- □ Drowsiness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Night Sweats
- □ Weakness
- □ Weight Gain
- □ Weight Loss

Eyes
- □ Deny All
- □ Blindness
- □ Blurred Vision
- □ Cataracts
- □ Change in Vision
- □ Double Vision
- □ Dry Eyes
- □ Eye Pain
- □ Field Cuts
- □ Glaucoma
- □ Sensitivity to Light
- □ Tearing
- □ Wears Glasses

Cardiovascular
- □ Deny All
- □ Angina
- □ Chest Pain
- □ Claudication
- □ Heart Murmur
- □ Heart Problems
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Orthopnea
- □ Palpitations
- □ Shortness of Breath
- □ Swelling of Legs
- □ Varicose Veins

Respiratory
- □ Deny All
- □ Asthma
- □ Bronchitis
- □ Dry Cough
- □ Productive Cough
- □ Coughing up Blood
- □ Difficulty Breathing
- □ Difficulty Sleeping
- □ Hemoptysis
- □ Pneumonia
- □ Sputum Production
- □ Wheezing

Musculoskeletal
- □ Deny All
- □ Arthritis
- □ Neck Pain
- □ Decreased Motion
- □ Gout
- □ Injuries
- □ Joint Pain
- □ Joint Stiffness
- □ Locking Joints
- □ Back Pain
- □ Muscle Cramps
- □ Muscle Pain
- □ Muscle Twitching
- □ Muscle Weakness
- □ Swelling

Integumentary
- □ Deny All
- □ Breast Lump/Pains
- □ Change in Nail Texture
- □ Change in Skin Color
- □ Eczema
- □ Hair Growth
- □ Hair Loss
- □ History of skin Disorders
- □ Hives
- □ Itching
- □ Paresthesia
- □ Rash
- □ Skin Lesions

Gastrointestinal
- □ Deny All
- □ Abdominal Pain
- □ Belching
- □ Black, Tarry Stools
- □ Constipation
- □ Diarrhea
- □ Heartburn
- □ Hemorrhoids
- □ Indigestion
- □ Jaundice
- □ Nausea
- □ Rectal Bleeding
- □ Abnormal Stool Caliber
- □ Abnormal Stool Consistency
- □ Vomiting
- □ Vomiting Blood

Genitourinary
- □ Deny All
- □ Birth Control Therapy
- □ Burning Urination
- □ Cramps
- □ Erectile Dysfunction
- □ Hesitancy/Dribbling
- □ Hormone Therapy
- □ Irregular Menstruation
- □ Lack of Bladder Control
- □ Prostate Problems
- □ Urine Retention
- □ Vaginal Bleeding
- □ Vaginal Discharge

ENMT
- □ Deny All
- □ Bad Breath
- □ Dentures
- □ Deviated Septum
- □ Difficulty Swallowing
- □ Discharge
- □ Dry Mouth
- □ Ear Drainage
- □ Ear Pain
- □ Frequent Sore Throats
- □ Head Injury
- □ Hearing Loss
- □ Hoarseness
- □ Loss of Smell
- □ Loss of Taste
- □ Nasal Congestion
- □ Nose Bleeds
- □ Post Nasal Drip
- □ Sinus Infections
- □ Runny Nose
- □ Snoring
- □ Sore Throat
- □ Ringing in Ears
- □ TMJ Problems
- □ Ulcers

Neurological
- □ Deny All
- □ Change in Concentration
- □ Change in Memory
- □ Dizziness
- □ Headache
- □ Imbalance
- □ Loss of Consciousness
- □ Loss of Memory
- □ Numbness
- □ Seizures
- □ Sleep Disturbance
- □ Slurred Speech
- □ Stress
- □ Strokes
- □ Tremors

Psychiatric
- □ Deny All
- □ Agitation
- □ Anxiety
- □ Appetite Change
- □ Behavioral Change
- □ Bipolar Disorder
- □ Confusion
- □ Convulsions
- □ Depression
- □ Homicidal Indication
- □ Insomnia
- □ Location Disorientation
- □ Memory Loss
- □ Substance Abuse
- □ Suicidal Indication
- □ Time Disorientation

Endocrine
- □ Deny All
- □ Cold Intolerance
- □ Diabetes
- □ Excessive Appetite
- □ Excessive Hunger
- □ Excessive Th8irst
- □ Goiter
- □ Hair Loss
- □ Heat Intolerance
- □ Unusual Hair Growth
- □ Voice Changes
- □

Hematologic
- □ Deny All
- □ Anemia
- □ Bleeding
- □ Blood Clotting
- □ Blood Transfusions
- □ Bruise Easily
- □ Lymph Node Swelling

Allergic/Immunologic
- □ Deny All
- □ History of Anaphylaxis
- □ Itchy Eyes

_____
Physician's Signature

_____
Date