DR. PHYLLIS B. BOOKS
INTAKE QUESTIONNAIRE

(Please fill in all the information – Please print)

Name _____ Date _____ File _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (O) _____ Referred by _____

Cell Phone _____ Fax _____ Email _____

Date of birth _____ Age _____ ☐ Female ☐ Male SS# _____ Marital Status M S D W

Occupation _____ Employer _____ Years Employed _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____

Person Responsible for this Account: _____

In case of Emergency, call: _____ *Relationship to patient:*

HEALTH REPORT:

Describe the chief symptoms that brought you to this office: _____

List other doctors seen for this and their diagnosis and treatment: _____

List names of relatives that have or have had similar problems _____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No If yes, please explain:

Have you had any x-rays taken in the past year? ☐ Yes ☐ No Females: are you now pregnant? ☐ Yes ☐ No

What diagnostic tests have you had; what were the results? _____

List dates of operations or serious diseases you have had: _____

Please relate any childhood accidents, injuries (especially to the head or tail bone), illness and medications. Include diagnosis' rendered: _____

Check any of the following conditions experienced during the past six months:

☐ Ear Infections	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Other:
☐ Asthma/Allergies	☐ Urination Problems	☐ Car Accident	☐ Temper Tantrums	☐ _____
☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Fitful Sleep	☐ _____

MUSCULO-SKELETAL

	Past	Present	Mild	Mod.	Severe		Past	Present	Mild	Mod.	Severe
Low back pain	☐	☐	☐	☐	☐	Leg pain/numbness/weakness	☐	☐	☐	☐	☐
Pain between shoulders	☐	☐	☐	☐	☐	General stiffness	☐	☐	☐	☐	☐
Neck problems	☐	☐	☐	☐	☐	Fractures	☐	☐	☐	☐	☐
Arm pain/weakness/numbness	☐	☐	☐	☐	☐	Foot/ankle problems	☐	☐	☐	☐	☐
Joint pain/stiffness	☐	☐	☐	☐	☐	Difficult chewing/clicking jaw	☐	☐	☐	☐	☐
Walking problems	☐	☐	☐	☐	☐	Shoulder problems	☐	☐	☐	☐	☐
Muscle cramps	☐	☐	☐	☐	☐	Knee problems	☐	☐	☐	☐	☐
						Hip problems	☐	☐	☐	☐	☐

Please grade the following stresses in order of increasing intensity:

0 = NO AWARENESS OF STRESS 1 = SLIGHTLY STRESSFUL 2 = MODERATELY STRESSFUL 3 = EXTREMELY STRESSFUL

Physical stress, trauma, abuse, including: falls, accidents, injuries, and impacts	0	1	2	3
Emotional/mental stress; includes: loss of loved ones, rapid change in life situation, trauma, abuse	0	1	2	3
Chemical stress; includes: drugs, smoke, fumes, food additives	0	1	2	3

Describe: _____

BIRTH AND FAMILY HISTORY:

Birth Place: ☐ Home ☐ Hospital ☐ Birth Center

Type of Delivery: ☐ Vaginal ☐ C-Section Length of labor? _____

Procedures: ☐ Forceps ☐ Vacuum extraction

Complications: _____

How many children in the family? _____ What number child are you? _____

Pre-natal experiences:

During pregnancy, mother:

☐ smoked ☐ under physical stress ☐ drank ☐ under emotional stress ☐ on meds ☐ under financial stress

EMOTIONAL/CHEMICAL FAMILY HISTORY:

		Siblings	*Mother's side*	*Father's side*	*Comments*
Depression	☐	☐	☐	☐	_____
Bipolar/manic dep.	☐	☐	☐	☐	_____
ADD	☐	☐	☐	☐	_____
Addictive personality	☐	☐	☐	☐	_____

Other significant emotional or chemical history of parents or relatives: _____

Home life

Role of mother: ☐ Available ☐ Supportive ☐ Good role model

Role of father: ☐ Available ☐ Supportive ☐ Good role model

BOOKS Family Health Center

SOCIAL/SCHOOL HISTORY:

Physical activities you enjoy: ☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate ☐ Hockey ☐ Basketball

☐ Volleyball ☐ Dance ☐ Golf ☐ Other _____

How would you describe your personality? _____

Interests and Hobbies? _____

What things do you do well? _____

What things are difficult for you? _____

What is your present reading skill grade level? 1 2 3 4 5 6 7 8 9 10 11 12 12+

If any of your difficulties (academic, social, athletic, etc.) were noticeable to others in school, how were they handled or responded to by your friends, parents, teachers, etc. _____

Discuss any difficulties with mathematics, coordination, concentration, reading, memory, spelling, etc.

At what age did you crawl? Walk? Talk?

GOALS FOR TREATMENT

It is important that you and the doctor have a clear understanding about what you want and need. Please let us know what your goals are for seeking care in this office:

How will you know when each goal is achieved? _____

I fully understand and agree that all services rendered me are charged directly to me and that I am directly responsible for payment unless other arrangements have been made in writing.

Patient's or Responsible Party's Signature _____ **Date** _____

If the patient is a minor, I, being the parent or guardian of the above, a minor, the age of ____ , do hereby consent, authorize and request the above office to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold the office harmless from any claims, suits, or damages or complications which may result from such treatment.

Parent's or Guardian's Signature _____ Date _____

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Phyllis Books, D.C. or anyone authorized by Phyllis Books, D.C. of any and all photographs which you have taken of me, negative or positive, and video tapes and audio tapes, for any purpose whatsoever without further compensation to me. All negatives and positives, together with their prints, and all video tapes and audio tapes, shall constitute the property of Phyllis Books, D.C. solely and completely. I hereby consent to the use of my name in any written material for private or public use. I affirm that I am 18 years of age or older and have read this release completely.

Name _____ Date _____

I am the legal guardian of the above-named minor and hereby approve the foregoing and consent to the terms mentioned above. I affirm I have the legal right to issue such consent.

Name _____ Date _____

Signature _____ Witness _____

Allergy Symptoms Survey Form

Today's Date:_____

Name: _____ Date of Birth: _____

Chief Complaint:

_____

_____

Symptoms	Please mark your level of discomfort 0= No Discomfort 10= Maximum Discomfort
Blurred Vision	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Dizziness	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Excessive Gas	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Fainting Spells	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Headaches	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Heartburn	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Indigestion	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Labored Breathing	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Loose Stool	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Morning Fatigue	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Night Sweats	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Poor Memory	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Sexual Impotency	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Swelling in the Joints	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Constipation	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Dry Skin	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Excessive Perspiration	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
General Fatigue	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Heart Palpitations	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Hot Flashes	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Insomnia	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Light Headaches	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Lump in Throat	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Nerves	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Numbness	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Poor/Excessive Appetite	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Shortness of Breath	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Throat Constriction	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Other (list)	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹
Other (list)	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Books Neural Therapy ™ Learning Survey

Client: _____ Date: _____

This general survey will provide us with an overview. Please use the side of this form to provide additional information.

In the left hand column, simply put a check mark if you have difficulty with the symptom. In the second column, please note the degree of difficulty from 1-10 (e.g. 1= tiny problem, 10= big problem)

Do you have difficulty with: (please check all that apply, either now or ever in your life)

	Date: 1-10	
		Reading (e.g. slow, eye wanders, eyes get tired quickly, etc)
		Remembering what you read
		Spelling
		Vision
		Seeing Colors (color blindness, seeing colors more vividly in one eye)
		Concentration
		Hyperactivity
		Sports/motor coordination (e.g. running, throwing a ball)
		Clumsy or accident prone
		Being rebellious/class clown/withdrawn
		Following instructions
		Following multiple instructions at one time
		Reversing numbers or letters
		Memory
		Self-esteem
		Remembering to turn in assignments
		Completing assignments/tasks
		Saying what you really mean
		Getting lost easily
		Confusing left and right
		Getting along with other children
		Getting along with other adults
		Getting along with authority figures (teachers, bosses, etc)
		Bed wetting
		Stuttering (now or in the past)
		Consistency in academic tests and achievements
		Frequently ask someone to repeat what they just said
		Have you ever fallen on your head or tail bone?
		Allergies (please list, if you know)

BOOKS
Family Health Center
SOUND BODIES... SOUND MINDS... SOUND SPIRITS

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays. The particular diagnosis and treatment plan for my file have been explained to me.

I understand that the practice of chiropractic is not an exact science, that individuals respond differently to treatment, and that there are no guarantees of the result of any treatment. I understand that the examination and treatment involves certain risks and those risks have been explained to me or provided to me. I do not expect the doctor to anticipate and explain all imaginable risks and/or contradictions, and I wish to rely on the doctor to exercise his judgment based on the facts known to be in my best interest during the course of treatment. I understand that the doctor is a licensed chiropractor in the state of Texas and such is licensed to employ objective or subjective means without the use of drugs, surgery, x-ray therapy, or radium therapy for the purpose of ascertaining the alignment of the vertebra and/or extremity when they are misaligned, in order to help cure or resolve musculoskeletal symptoms that result from such misalignment.

I understand any and all doctors employed by this office disclaim being able to treat me for any maladies or symptoms that I may be experiencing that may not be related to the injuries reported to the doctor. It is not expressed or implied in this office that the treatment offered by the doctor will specifically cure any symptoms I may be experiencing in any other part of my body.

I have read and understood the above consent for chiropractic treatments and care. I have also had the opportunity to ask questions regarding this consent and my treatment plan. Further, I understand all charges incurred at **BOOKS FAMILY HEALTH CENTER** are ultimately my responsibility regardless of payment availability from another source(s). I therefore authorize examination and treatment to be performed at **BOOKS FAMILY HEALTH CENTER.**

Patient's Name: (PLEASE PRINT) _____

Patient's Signature: _____ Date: _____

Name of Custodial Parent or Legal Guardian of Minor: _____

Parent/Guardian Signature: _____ Date: _____

BOOKS
Family Health Center
SOUND BODIES... SOUND MINDS... SOUND SPIRITS

Patient Guidelines

Our office wishes to provide our patients with the best care possible, so we ask all new patients to please carefully read the following information. Do not hesitate to ask the front desk any questions or concerns you may have. When finished reading, please initial as proof that you have read and understand all of the following information. Thank you.

Forms of Payment: We accept the following forms of payment, if you have any questions please ask.

- Cash
- Check
- MasterCard/Visa
- Care Credit – 3, 6, 12 month no interest payment plan

Appointments: Please call in advance to make an appointment to ensure that there is an appointment time available.

Cancellations/No Show: Unless due to an emergency, there will be a $35 no show fee strictly enforced for any scheduled appointment missed that was not called and rescheduled 24 hours in advance. BFHC reserves the right to offer one (1) grace period. If a patient repeatedly is unable to make scheduled appointments, Dr. Books reserves the right to terminate care with the patient.

Cash Discounts: Patients who pay for care in specified pre-paid package may be eligible to receive a discount. Patients will be advised to the package(s) that will best suit their needs.

Request for Copies of Medical Records: Kindly give our office 48 hours notice to prepare your request. If a patient has a question about their Patient Rights they may contact the Financial (Insurance) Clerk. Patients will be required to sign a release of record form.

Phone and Address Changes: Please notify us immediately so that we may update our records.

_____

Signature of Patient/Guardian Date

ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, AND TREATMENT AGREEMENT

Consideration: In order to facilitate the ability of **Dr. Phyllis Books, D.C., dba Books Family Health Center** to collect its charges directly from various payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the office's services, agree to the following and direct all payers as follow:

Partial Assignment of the Cause of Action & Assignment of Proceeds: I, hereby assign, in so far as permitted by law, all of my rights, remedies and benefits **to Dr. Phyllis Books, D.C., dba Books Family Health Center** as well as any and all causes of action that I might have now or in the future against any payer to the extent of my charges, the right to settle or otherwise resolve such causes of action as the office sees fit. I further assign my right to receive any proceeds from any payer to the above-mentioned provider with respect to my charges. Consistent with these rights, I hereby direct any and all payers, to pay the proceeds directly and immediately to and exclusively in the name of **Books Family Health Center** in the amount of my charges.

Other terms: I understand that I remain personally responsible for my charges. Consistent with the law or contract, I agree to pay the full amount of my charges upon demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the office shall not constitute a waiver of the office's right to receive payment in full. I understand that at any time, I can request a copy of my total charges.

In the event that I retain one or more attorneys to assist me in collecting any proceeds, I direct each attorney to issue an irrevocable letter of protection **to Books Family Health Center** regarding my charges. I further direct each attorney to provide immediate notice to the office regarding any proceeds received by the attorney, to promptly pay the charges in full out of such proceeds and to provide a full accounting of such proceeds to the billing office.

I authorize and direct the office to submit my charges to any and all payers including, without limit, my health benefit plan. I understand however, that in the event that my charges are submitted to more than one payer, I hereby authorize and direct the office to apply any proceeds received from one payer to any reductions, write offs or discounts, issued by another.

I authorize **Books Family Health Center** to endorse or sign my name on any and all checks listing me as a payee, which are received by the office for payment of charges incurred by me, my spouse or my dependents. I further authorize the office to apply any credit balances on my charges to any other outstanding charges still owed by me, my spouse or my dependents, regardless of whether these other charges are related to my condition.

This agreement shall not be modified or revoked without the mutual written consent of the office and myself. I also agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interests of **Books Family Health Center** and myself.

I have read and understood the conditions, terms and purpose of this contract.

Patient Name: (PLEASE PRINT) _____

Patient Signature:_____Date: _____

Name of Custodial Parent of Legal Guardian, on behalf of the patient:

Parent/Guardian Signature: _____Date: _____

HIPAA NOTICE OF PRIVACY PRACTICE
Effective Date: May 1, 2008

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We respect patient confidentiality and only release personal health information about you in accordance with State and Federal law. This notice describes our policies related to the use of the records of your care generated by Books Family Health Center.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Books Family Health Center. This includes:

Treatment

With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of Books Family Health Center that we are consulting with or referring you to.

Payment

Information will be used to obtain payment for the treatment and services provided. This will include providing you with insurance forms for you to complete and submit.

Healthcare Operations

We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff. We may also call you by name in the waiting room when your Books Family Health Center staff is ready to see you. We may use or disclose your protected health information, as necessary, to contact you for your appointment.

Information Disclosed Without Your Consent.

Under State and Federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies

Sufficient information may be shared to address the immediate emergency you are facing.

Follow up Appointments

We will be contacting you to remind you of future appointments, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

As Required by Law

This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases, or suspected abuse and neglect such as child, elder or institutional abuse.

Coroners, Funeral Directors

We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purpose of carrying out their duties.

Governmental Requirements

We may disclose information to a health oversight agency for the activities authorized by law, such as audits, investigations, inspections, and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others

If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS

You have the following rights under State and Federal law:

Copy of Record

You are entitled to inspect the personal health record Books Family Health Center has generated about you. However, under Federal Law, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. We may charge you a reasonable fee for copying and mailing your record.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another healthcare professional.

Release of Records

You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others whom you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record

You may ask us not to use or disclose part of the personal health information. This request must be in writing. Books Family Health Center is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to Books Family Health Center who will consult with the staff involved in your care to determine if the request can be granted.

Contacting

You may request that we send information to another address or by alternative means. We will honor such requests as long as it is reasonable, and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

Amending Record

If you believe that something in your record is incorrect or incomplete, you may request we amend it. In certain cases, we may deny your request. If we deny your request for an amendment, you have a right to file a statement that you disagree with us. We will then file our response, and your statement and our response will be added to your record.

Accounting for Disclosures

You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operation's purposes, or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release.

Questions and Complaints

If you have any questions or complaints you may contact Books Family Health Center in writing at our office. You also may complain to the Secretary of Health and Human Services if you believe Books Family Health Center has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy

Books Family Health Center reserves the right to change its privacy policy at any time based on the needs of Books Family Health Center and changes in State and Federal law. You then have the right to object or withdraw the use provided in this notice. A current copy of our Privacy Policy will be posted in the lobby.

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Print Name: _____ Signature: _____

Date: _____