



Cesar A. Longoria BS, DC  
 4543 Post Oak Place Drive #100  
 Houston, TX 77027  
 Ph: 210-556-6082 Fax: 281-557-6513

\*Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Full-time or Part-time (circle one)  
**OR** School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL HISTORY:**

Name of Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 List of Allergies: \_\_\_\_\_  
 Do you: Smoke \_\_\_\_\_ or Drink \_\_\_\_\_ Frequency: \_\_\_\_\_

**Please list all medication or vitamins, as well as dosage and frequency**

Medication	Dosage	Frequency

Or, if you do not take any prescribed medication initial here: \_\_\_\_\_

**Please list all hospitalizations, surgeries, major accidents or other past medical history**

Type	Date	Reason

Or, if you do not have any past medical history initial here: \_\_\_\_\_

**MEDICAL HISTORY-REVIEW OF SYSTEMS**

Please LIST any and all medical problems that apply to you (past or present):


Describe any of the above: \_\_\_\_\_

If you deny all of the above and all other, initial here: \_\_\_\_\_

**FEMALE ONLY:**

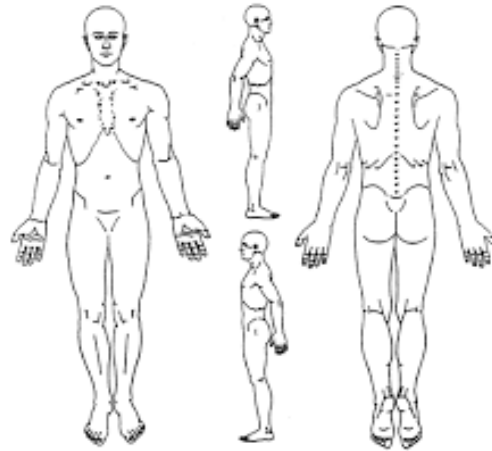
Are you pregnant? Yes or No \_\_\_\_\_ Date of Last Menstrual Cycle: \_\_\_\_\_

**REASON FOR VISIT**

What is your area(s) of complaint? : \_\_\_\_\_  
 When did this issue begin? \_\_\_\_\_ Have you seen any other physicians? \_\_\_\_\_  
 If so, who? \_\_\_\_\_  
 How to you hear about our clinic? \_\_\_\_\_  
 Is your pain (circle one): Getting better    Staying the same    Getting worse

**Use the following symbols to describe your pain on the diagram:**

- ^^^= Achy
- ///= Numbness/Pins & Needles
- >>>= Stabbing
- XXX= Burning
- +++ = Throbbing



Rate your pain from 0 (no pain) to 10 (worst pain):

\_\_\_\_\_

**INFORMED CONSENT**

Please read this section in its entirety. Please ask questions before you sign if there is anything that is unclear.

**Chiropractic Adjustment/Assessment/Analysis/Treatment**

During the course of your treatment we may recommend and perform the following. Please circle ones in which you **DO NOT** consent to:

Spinal or extremity manipulation	Spinal and muscle palpation	Orthopedic testing	Postural analysis
Range of motion testing	Muscle testing	Ultrasound	Exercise therapy
Hot/Cold Pack	Neurological testing	Manual therapy	Nutritional Supplementation

**Availability of Other Treatment** (May include, but not limited to):



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-Over the counter medication  
-Medical care (prescription medication)

-Rest  
-Surgery

**The Material Risks Inherent in Chiropractic Treatment**

As with any healthcare procedure, there are certain complications associated. These complications include, but are not limited to: fracture, disc injuries, dislocation, muscle strain and burns. Some types of cervical manipulations have been associated with injuries to arteries to the neck leading to or contributing to complications including stroke. Stroke has been the subject of tremendous disagreement. The incidences of stroke are extremely rare and are estimated to occur one in million, to one in five million cervical manipulations. I will make every reasonable effort during my examination and review of your medical history to screen for contraindications to care, however, if you have a condition that would be otherwise not come to my attention, or fail to disclose in your intake, it is your responsibility to bring it to my attention.

**I have read and fully understand the informed consent and material risks inherent in chiropractic treatment.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian Name (if applicable): \_\_\_\_\_  
Signature of patient or Guardian: \_\_\_\_\_

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**INNOVATIVE SPORTS MEDICINE HIPPA PRIVACY RECEIPT AKNOWLEGMENT**

Innovative Sports Medicine has given me a copy of their Privacy Notice. By my signature, I acknowledge that I have received and understand how my protected health information will be handled.

PatientName: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian Name (if applicable): \_\_\_\_\_  
Signature of patient or Guardian: \_\_\_\_\_



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