BURLEIGH HEALTH CENTER & REHAB
7825 HIGHWAY 6 NORTH, SUITE 101 ♦ HOUSTON, TEXAS 77095
TEL: 832-237-3331
FAX: 832-237-4638
REVISED: 01/01/2025

NEW PATIENT INFORMATION

DATE: _____

Please Print

NAME _____ AGE _____ SEX _____ DOB _____
ADDRESS _____ CITY/STATE/ZIP _____
HOME PHONE _____ WORK _____ CELL _____
EMAIL _____ NUMBER OF CHILDREN _____
RACE ☐ AMERICAN INDIAN ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN MARITAL ☐ MARRIED ☐ SINGLE ☐ OTHER
ETHNICITY ☐ CAUCASIAN/WHITE ☐ HISPANIC ☐ OTHER STATUS ☐ DIVORCED ☐ WIDOWED

EMPLOYMENT ☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED OCCUPATION _____
EMPLOYER _____ EMPLOYER PHONE _____
ADDRESS _____ CITY/STATE/ZIP _____
EMERGENCY CONTACT _____ TELEPHONE _____

HEALTH INSURANCE INFORMATION

INSURANCE		POLICY ID NUMBER	
POLICY HOLDER NAME		GROUP NUMBER	
INSURED DATE OF BIRTH		RELATIONSHIP TO INSURED	

SECONDARY HEALTH INSURANCE INFORMATION

INSURANCE		POLICY ID NUMBER	
POLICY HOLDER NAME		GROUP NUMBER	
INSURED DATE OF BIRTH		RELATIONSHIP TO INSURED	

PERSONAL INJURY CLAIM (PIP)

INSURANCE		CLAIM NUMBER	
POLICY HOLDER NAME		AGENT CONTACT	
PROPERTY DAMAGE		TELEPHONE NUMBER	

THIRD PARTY CLAIM

INSURANCE		CLAIM NUMBER	
POLICY HOLDER NAME		AGENT CONTACT	
PROPERTY DAMAGE		TELEPHONE NUMBER	

REASON FOR VISIT

WHAT IS YOUR PROBLEM OR SYMPTOMS TODAY? _____
HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? ☐ NO ☐ YES IF YES, WHO?
WHAT TESTS AND/OR PROCEDURES HAVE BEEN PERFORMED? ☐ X-RAY ☐ MRI ☐ SURGERY ☐ TRANSPLANT ☐ OTHER
HAVE YOU HAD THIS PROBLEM OR SYMPTOMS IN THE PAST? ☐ NO ☐ YES IF YES, EXPLAIN:
HAVE YOU TRIED ANY OTHER TREATMENTS FOR THIS? ☐ NO ☐ YES IF YES, EXPLAIN:

DO WE HAVE PERMISSION TO COMMUNICATE ELECTRONICALLY WITH YOU VIA EMAIL AND TEXT?

☐ YES ☐ NO

DRIVERS LICENSE & INSURANCE CARD
TO BE SCANNED FOR YOUR PERMANENT MEDICAL RECORD

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PAST HISTORY

LIST CURRENT OR PAST MEDICAL CONDITIONS (EX: DIABETES. STROKE, HEART ATTACK, HIGH BLOOD PRESURE, CANCER):

LIST ANY ACCIDENTS OR TRAUMAS YOU HAVE EXPERIENCED:

ACCIDENT/TRAUMA	DATE

LIST ALL SURGERIES YOU HAVE HAD:

SURGERY TYPE	DATE

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? ☐ YES ☐ NO

IF YES, EXPLAIN:

TYPE
☐ ALCOHOL
☐ OPIATE

SMOKING STATUS

DO YOU USE TOBACCO

☐ NEVER
☐ FORMER TOBACCO USE — TYPE: ☐ CIGARETTE ☐ VAPING ☐ CIGAR/PIPE ☐ CHEWING
☐ CURRENT EVERYDAY TOBACCO USE — TYPE: ☐ CIGARETTE ☐ VAPING ☐ CIGAR/PIPE ☐ CHEWING

HOW OLD WERE YOU WHEN YOU STARTED USING TOBACCO? _____
NUMBER OF YEARS USING TOBACCO? _____
WHAT YEAR DID YOU QUIT? _____

ALLERGIES

LIST ALL DRUG, CHEMICAL, LATEX, IODINE ALLERGIES: _____

MEDICATIONS – LIST ALL CURRENT MEDICATIONS ☐ SEE ATTACHED LIST

MEDICATION NAME	TAKEN FOR	DOSAGE / STRENGTH	HOW OFTEN (ex: 1x Day)

FEMALES ONLY:

ARE YOU PREGNANT? ☐YES ☐NO LAST MENSTRUAL CYCLE DATE: _____ DUE DATE: _____

FAMILY HISTORY - PLEASE LIST MEDICAL ISSUES: Cancer, Heart Trouble, Diabetes, etc. for any biological family member.

DESCRIBE YOUR PAIN

WHERE DO YOU HURT? _____
HOW SEVERE IS YOU PAIN BETWEEN 0 – 10 _____
HOW OFTEN DO YOU HAVE PAIN? _____
HOW LONG HAS THIS BEEN GOING ON? _____
DESCRIBE YOUR PAIN (DULL, ACHE, SHARP, COLD, HOT)? _____
IS THERE ANY ARM / LEG PAIN, NUMBNESS, TINGLING OR WEAKNESS? _____
WHAT ACTIVITIES CAUSE YOU TO NOTICE YOUR PAIN? _____
DOES REST MAKE CONDITION BETTER OR WORSE? _____
DOES PAIN GET WORSE AS DAY GOES ON? ☐ YES ☐ NO
DOES PAIN IMPROVE AS DAY GOES ON? ☐ YES ☐ NO
HAVE YOU HAD THESE SYMPTOMS BEFORE? ☐ YES ☐ NO

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ACCIDENT / INJURY

DATE OF ACCIDENT: _____ **TIME:** _____ ☐ **AM** ☐ **PM**

ACCIDENT DETAILS

DRIVER?	☐ YES ☐ NO
PASSENGER?	☐ YES ☐ NO
WEARING SEAT BELT?	☐ YES ☐ NO
AIRBAGS DEPLOY?	☐ YES ☐ NO
UNCONSCIOUS?	☐ YES ☐ NO
TRANSPORTED BY AMBULANCE?	☐ YES ☐ NO
TREATED IN HOSPITAL, URGENT CARE OR ER ROOM?	☐ YES ☐ NO

VEHICLE DAMAGE

MINIMAL – MODERATE
SEVERE – TOTALED
WAS VEHICLE TOWED AWAY? ☐ YES ☐ NO
POLICE REPORT ☐ YES ☐ NO
NAME OF POLICE DEPARTMENT: _____

WHAT HOSPITAL, URGENT CARE OR ER DID YOU GO TO? _____ **DATE OF VISIT:** _____

PLEASE FILL OUT PAST OR MEDICAL CONIDITIONS BELOW.

☐ **CHECK IF YOU DO NOT HAVE PAST OR PRESENT MEDICAL CONDITIONS**

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Select ALL symptoms that you have had in the past as well as those that you presently have

PAST / PRESENT

Constitutional
- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ High Fever
- ☐ ☐ Night Sweats
- ☐ ☐ Weight Change

Eyes
- ☐ ☐ Blindness
- ☐ ☐ Blurred Vision
- ☐ ☐ Cataracts
- ☐ ☐ Pain
- ☐ ☐ Watery

ENMT *Ears*
- ☐ ☐ Ear Aches
- ☐ ☐ Hearing Loss
- ☐ ☐ Tinnitus
- ☐ ☐ Vertigo

Nose
- ☐ ☐ Congestion
- ☐ ☐ Discharge
- ☐ ☐ Rhinitis
- ☐ ☐ Sinus Pain

Mouth
- ☐ ☐ Bleeding Gums
- ☐ ☐ Dental Pain
- ☐ ☐ Dry Mouth
- ☐ ☐ Taste Abnormality

Throat
- ☐ ☐ Laryngitis
- ☐ ☐ Lump in Throat
- ☐ ☐ Sore Throat
- ☐ ☐ Voice Changes

Chest/Breast
- ☐ ☐ Discharge
- ☐ ☐ Mass
- ☐ ☐ Nipple Abnormality
- ☐ ☐ Pain

Respiratory
- ☐ ☐ Asthma
- ☐ ☐ Cough
- ☐ ☐ COPD
- ☐ ☐ Interstitial Lung Disease
- ☐ ☐ Pulmonary Fibrosis
- ☐ ☐ Shortness of Breath
- ☐ ☐ Wheezing

PAST / PRESENT

Cardiovascular
- ☐ ☐ Chest Pain
- ☐ ☐ Heart Attack
- ☐ ☐ Hypertension
- ☐ ☐ Murmur
- ☐ ☐ Palpitations
- ☐ ☐ Rapid Heart Beat
- ☐ ☐ Stroke

Gastrointestinal
- ☐ ☐ Abdominal Pain
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ GERD
- ☐ ☐ Nausea
- ☐ ☐ Ulcers

Genitourinary
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ Hematuria (Blood in Urine)
- ☐ ☐ Kidney Stones
- ☐ ☐ Prostate Enlarged
- ☐ ☐ STD
- ☐ ☐ UTI Symptoms

Integumentary
- ☐ ☐ Bruising
- ☐ ☐ Color Change
- ☐ ☐ Dry Skin
- ☐ ☐ Itching
- ☐ ☐ New or Changing Moles
- ☐ ☐ Rash

Musculoskeletal
- ☐ ☐ Limitation of Movement
- ☐ ☐ Extremity Pain
- ☐ ☐ Spine Pain
- ☐ ☐ Trauma or Recent Injury

Neuro *Autonominc*
- ☐ ☐ Cyanosis (Blue skin)
- ☐ ☐ Erythema (Red skin)
- ☐ ☐ Pallor (White skin)

Cranial Nerves
- ☐ ☐ Equilibrium Distrubance
- ☐ ☐ Facial Weakness
- ☐ ☐ Hearing Disturbance
- ☐ ☐ Smell Disturbance
- ☐ ☐ Speech, Swallowing Disturbance
- ☐ ☐ Visual Disturbance

PAST / PRESENT

Neuro *Head*
- ☐ ☐ Blackout
- ☐ ☐ Headache
- ☐ ☐ Memory Loss
- ☐ ☐ Vertigo

Motor
- ☐ ☐ Convulsions/Seizures
- ☐ ☐ Involuntary Motion
- ☐ ☐ Muscle Atrophy
- ☐ ☐ Paralysis

Sensory
- ☐ ☐ Decreased Sensation
- ☐ ☐ Numbness
- ☐ ☐ Tingling
- ☐ ☐ Sensation Loss

Psyche
- ☐ ☐ Anxiety Problems
- ☐ ☐ Bipolar
- ☐ ☐ Dementia
- ☐ ☐ Depression
- ☐ ☐ Hallucinations

Endocrine
- ☐ ☐ Diabetes
- ☐ ☐ Excessive Sweating
- ☐ ☐ Excessive Thirst/Hunger
- ☐ ☐ Heat or Cold Intolerance
- ☐ ☐ Obesity
- ☐ ☐ Thyroid Disease

Hematic/Lymph
- ☐ ☐ Anemia
- ☐ ☐ Clotting Problems
- ☐ ☐ Hepatitis
- ☐ ☐ HIV

Allergies
- ☐ ☐ Allergy
- ☐ ☐ Conjunctivitis
- ☐ ☐ Hay Fever

Other
- ☐ ☐ _____
- ☐ ☐ _____
- ☐ ☐ _____
- ☐ ☐ _____
- ☐ ☐ _____

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION TO TREAT – LIEN

Welcome to our multi-specialty group practice. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents, or any other items. Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests, and treatments medically necessary & to release all information pertinent to your health, insurance, or benefits to any applicable parties on your behalf. Our Facility is committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality healthcare services delivered with dignity and concern. HIPAA requires that we have you sign the federally governed Health Care Privacy Notice. You may receive a photocopy of this document that you have signed just by asking one of our staff.

General Consent to Treat I have the legal right to consent to medical treatment because (a) I am the patient or (b) I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means the patient:

General Consent to Treat

_____ **INITIALS**

I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing, photographs or films related to care and treatment, including, but not limited to, physical therapy, pulmonary rehab physical therapy, and manipulation as are considered therapeutically necessary on the basis of findings during the course of said treatment. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff has made any guarantee or promise as to the results that will be obtained.

Sharing Records for Treatment

_____ **INITIALS**

We share medical records electronically with referring physicians, and other health care providers to allow and promote continuity of care among providers.

Voicemail and Text Notifications

_____ **INITIALS**

I understand and agree that my provider may contact me using automated calls, emails and/or text messages sent to my landline and/or mobile device. These communications may notify me of appointments, preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff. I understand that my provider's HIPAA Privacy Notice is posted on the facility reception wall and that I may request a paper copy at my provider's reception desk.

Acknowledgment: Notice of Privacy Practices

_____ **INITIALS**

I acknowledge Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC Notice of Privacy Practices ("Notice"). The Notice explains how Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC may use and disclose the patient's protected health information for treatment, payment, and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC Privacy Office at (832) 237-3331. I understand that my provider's Privacy Notice is available on my provider's reception area wall, website and that I may request a paper copy at my provider's reception desk. I hereby acknowledge that I have read and/or received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information and consent to my treatment by my provider. This form and my assignment of benefits apply and extend to subsequent visits and appointments with all Burleigh Health Center & Rehab, P.L.L.C. and/or Burleigh Chiropractic Center, P.C. affiliated providers.

No-Show and Missed Appointment Policy

_____ **INITIALS**

We at the Burleigh Health Center & Rehab, P.L.L.C. and/or Burleigh Chiropractic Center, P.C. understand that you may at times need to cancel or reschedule an appointment due to emergencies or other unexpected issues. If you are unable to keep your appointment, please notify us at least 24 hours prior to your scheduled appointment time. You can reschedule or cancel appointments by calling our clinic. You can also utilize the Online Reminder Messaging Portal for canceling appointments or contacting the clinic. **A FEE MAY APPLY FOR "NO SHOW OR MISSED APPOINTMENTS" OF $25.00.**

I have read this form, or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

.

☒ _____ **SIGNATURE**

_____ **DATE**

BURLEIGH HEALTH CENTER & REHAB, PLLC
BURLEIGH CHIROPRACTIC CENTER PC
TEL: 832-237-3331 ♦ FAX: 832-237-4638

PLEASE FAX RECORDS TO (832) 237-4638

MEDICAL RECORDS REQUEST FORM

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC may verify your identity/guardianship.

PATIENT INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **TELEPHONE:** _____

CITY: _____ **STATE:** _____ _____

AUTHORIZATION TO RELEASE MY MEDICAL RECORDS. I AUTHORIZE THE FOLLOWING TO DISCLOSE TO BURLEIGH HEALTH CENTER & REHAB, PLLC AND/OR BURLEIGH CHIROPRACTIC CENTER, PC FOR THE PURPOSE OF CONTINUING MEDICAL CARE AND/OR MEDICAL TREATMENT.

CLINIC: _____ **PROVIDER NAME:** _____

TEL/FAX: _____ **DATE(S) OF SERVICE:** _____

INFORMATION TO RELEASE:

- ☐ All Health Information
- ☐ History / Physical Exam
- ☐ Progress Notes
- ☐ Lab Results
- ☐ EKG/Cardiology Reports
- ☐ Operative Reports
- ☐ Radiology Reports and/or Images
- ☐ ER Records
- ☐ Date of Service: _____

DISCLOSURE OF SENSITIVE INFORMATION

You have the right to refuse disclosure and prevent any other person from disclosing sensitive information related to the following conditions, treatments, or testing. To exclude this information from disclosure, check the appropriate checkbox(es).

☒ I authorize the disclosure of **ALL** sensitive information ☐ I DO NOT authorize the disclosure of **ALL** sensitive information

TO BE COMPLETED ONLY FOR THIRD-PARTY DISCLOSURES. (PERSONAL USE, SKIP THIS SECTION)

I want the requested medical records to be sent to the third-party (for example, an employer or a school) I have indicated below. My completion of this form serves as authorization for Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC to disclose these records to this person or group. I understand that once my information leaves Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC, Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

NAME: _____ **TELEPHONE:** _____

ADDRESS: _____ **CITY / STATE / ZIP:** _____

TERMS OF AUTHORIZATION: I understand this authorization may be revoked in writing at any time, according to the instructions in Burleigh Health Center & Rehab, PLLC and/or Burleigh Chiropractic Center, PC Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated: _____. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes.

Signature: ☒_____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance, and mental health treatment (Texas Family Code 32.003).

Minor's Signature: _____ **Date:** _____