

# *Realigning the Soul Chiropractic*

*1842 Snake River Rd. Katy, TX 77449*

*281-206-2348 [www.realigningthesoul.com](http://www.realigningthesoul.com)*



Congratulations on choosing to improve your quality of life and health!

When you begin Chiropractic care, you will be exploring the incredible healing power of your own body, your own INNATE HEALING potential. Whether you come to us for help with physical pain and symptoms, to strengthen your spine and body, to increase your present state of awareness, to increase the flexibility of your nervous system and improve your quality of life, whatever the reason we welcome you. During this process, Dr. Marlene Tellez will be your healing coach. You will have the opportunity to gain a stronger, healthier and more flexible spine and to develop long-term strategies for reclaiming your power for your health! Taking responsibility is at the core of health and peace!

Your initial visit will include a complete history and consultation along with your first gentle chiropractic adjustment. A second visit will also be arranged for your report of findings to review exam results, discuss recommendations for care, and answer your questions. By the end of this second visit you will have all the information you need to make an informed decision about continuing care.

## To prepare for your initial visit, please follow this checklist:

- **Call** the office to set up a special appointment time **281-206-2348**
- Visit [www.realigningthesoul.com](http://www.realigningthesoul.com) for new patient forms.
- Please **READ & SIGN** the “*Informed Consent Form*”.
- **Thoroughly complete** the “*Patient Initial Questionnaire*”.
- **Thoroughly complete** the “*Life History Form*”.
- **Thoroughly complete** the “*Privacy Notice Agreement*”.
- Plan to spend one hour in the office for your 1<sup>st</sup> visit.
- Please **arrive 10 minutes prior** to your scheduled appointment time!

Your healing begins with gentle, honoring, light force adjustments to reduce abnormal spinal cord tension and increase your spinal awareness. As your body begins to re-awaken and heal, you may observe many changes in your physical, mental, and emotional sub-systems. I am honored to be with you on this journey as we realign the soul to your full potential. Congratulations, you are in the right place and on your way to a better life!

With Love,

Dr. Marlene Tellez

## Informed Consent Form

I, \_\_\_\_\_ hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor. A low force technique is utilized along with the use of the arthrostim, percussor, and activator. The Doctor may use one or all of these during a treatment. The Doctor's technique consists of gentle touch contacts along the spine and body to achieve greater communication between the brain and body and new sensory and motor strategies.

**The nature of the adjustment:**

The Doctor will use her hands or a mechanical device upon your body in such a way as to move your joints and the adjacent soft tissue. That may cause an audible "pop" or "click" as you may have experience when you crack your knuckles. You may feel or sense movement.

**The material risks inherent to the chiropractic adjustment:**

As with any health care procedures, there are certain complications which may arise during a chiropractic adjustment. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including muscle strain, possible bruising, fracture, stroke, and/or release of emboli. Some patients will feel stiffness and soreness following the first few days of treatment.

**Probability of risks occurring:**

Any type of complication is very rare and generally results from some underlying weakness of the bone, which we check for during history taking and examination. Since every risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury.

By signing below, I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I acknowledge that no guarantee of assurance as to the results that may be obtained from this treatment have been given to me. I hereby give my consent to Dr. Marlene Tellez to perform examination and treatment as deemed necessary for my care.

### For Females Only

This is to certify that, to the best of my knowledge, I am not pregnant. Date of Last Menstrual period \_\_\_\_\_  
If pregnant, Dr. Tellez will not be using the percussor on or around the fetus. \_\_\_\_\_(Initials)

If eligible for Medicare, I understand that the services I receive are **not** covered under Medicare. \_\_\_\_\_

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
PRINTED NAME OF WITNESS

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
DATE

## Treatment and Services Policy Agreement

Welcome!

I am delighted that you're here, and I am committed to providing you with quality care. Trust and openness are essential for effective treatment.

Payment is due at time of service. Checks should be made payable to Dr. Marlene Tellez or Realigning the Soul Chiropractic. For your convenience, I also accept credit and debit cards. However, I DO NOT accept Insurance or MEDICARE at this time.

If you find that you are unable to keep an appointment, please call and leave a message. **I would appreciate a 24 hour notice. There will be a charge for missed appointments and those not cancelled 24 hours in advance.**

I look forward to working with you,  
Dr. Marlene Tellez

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I have read and understand this agreement regarding services and policies. I understand that I may have a copy of this agreement for future references. I agree to be responsible for all charges for myself/ my spouse/ my children.

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PRINTED NAME OF PATIENT

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SIGNATURE OF PATIENT

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DATE

**PATIENT INITIAL QUESTIONNAIRE**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Your quality of life is our concern. Please complete this form by listing your health concerns (in order of priority) and rate the severity of each from 1-10 with 10 being the worst.**

**I. Chief Physical Complaints**

- 1. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 2. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 3. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 4. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 5. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

**II. Chief Emotional Complaints**

- 1. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 2. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 3. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 4. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 5. \_\_\_\_\_ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

**III. Please list any other concerns that you would like the doctor to know about:**

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**IV. What would you like to accomplish from your healing process in our office?**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

## Life History Form

The intent of this form is to assist you in your healing process by initiating a thoughtful recognition of your life experiences. Life is a cumulative process; use this form to increase your understanding and appreciation of your own life process and accumulation of stressors, both positive and negative.

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### PATIENT'S FULL NAME:

\_\_\_\_\_

“Nick Name” or name you like to be called if different:

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Would you like to subscribe to our Email Newsletter?  Yes  No Email Appointment Reminders?  Yes  No

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Relationship Status: \_\_\_\_\_

Spouse or Partner's Name: \_\_\_\_\_ Number of Children: \_\_\_\_\_

### REFERRAL SOURCE: The majority of our practice members come from direct in house referrals.

Were you referred by a patient of ours?  Yes  No Patient's Name: \_\_\_\_\_

Were you referred by the internet?  Yes  No If so, any particular directory or site? \_\_\_\_\_

Were you referred by:  Other: \_\_\_\_\_

Primary Contact:  Self  Spouse  Other \_\_\_\_\_

Employment Status:  Full time  Part time  Retired  Unemployed  Other \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Financially Responsible Party:  Self  Spouse

Parent  Other \_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HEALTH HISTORY:

Have you ever received any form of Chiropractic Care?  Yes  No

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods he or she used?

\_\_\_\_\_

When was your last visit? \_\_\_\_\_ If you stopped, why did you stop? \_\_\_\_\_

\_\_\_\_\_

Were you pleased with his or her service?  Yes  No  Somewhat \_\_\_\_\_

Has anyone ever taken x-rays of your spine?  Yes  No When? \_\_\_\_\_

If yes, who would you need to contact for copies of your x-rays? \_\_\_\_\_

Does anyone in your immediate family receive chiropractic adjustments?  Yes  No \_\_\_\_\_

The practice of chiropractic is based upon the location and adjustment of Vertebral Subluxations. Spinal Subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL/MENTAL in nature.

**GENERAL - PHYSICAL STRESS:** Next to each potential cause of vertebral subluxation is a check box. Please check 'P' for Past, 'C' for Current (or both if they apply) under the level of trauma severity.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib, bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports Impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls down/up steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls on ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Armed services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

Have you ever been knocked unconscious? Yes No Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Have you ever used crutches, a walker, or cane? Yes No Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Have you ever broken any bones? Yes No Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? Yes No

Date: \_\_\_\_\_ Comments: \_\_\_\_\_

Have you had extensive dental or orthodontial work done? Yes No Date: \_\_\_\_\_

Comments: \_\_\_\_\_

Have you served in the military? Yes No Date: \_\_\_\_\_ to \_\_\_\_\_ Were you involved in combat? Yes No

During the day, I: sit stand walk drive do desk work phone work mechanical work heavy lifting

I exercise: daily weekly monthly List Details: \_\_\_\_\_

**AUTOMOBILE ACCIDENTS:** Have you (even as a passenger and even if you do not think you were hurt) been involved in a vehicular collision or near collision? Please list approximate dates and severity (Mild, Moderate, Severe or Extreme)?

Automobile: \_\_\_\_\_  
 \_\_\_\_\_

Bus, bicycle, motorcycle, train, airplane, mo-ped, or other vehicles: \_\_\_\_\_

**MEDICAL TREATMENT:** Have you ever been hospitalized? Yes No When? And Why

\_\_\_\_\_

Have you ever had surgery? Yes No If yes, please explain: \_\_\_\_\_

Do you still have all your body parts? Yes No If no, please explain: \_\_\_\_\_

Have you had: a spinal tap spinal injections physiotherapy neck collar spinal brace traction  
heel lift radiation treatments corrective shoes or bars on shoes extensive diagnostic x-rays  
acupuncture chemotherapy blood transfusion bone in a cast or immobilized?

**GENERAL - CHEMICAL STRESS:** Are you now taking any drug (prescription, over-the-counter or recreational) regularly?

Drug: \_\_\_\_\_ Date Prescribed: \_\_\_\_\_ Reason: \_\_\_\_\_

Drug: \_\_\_\_\_ Date Prescribed: \_\_\_\_\_ Reason: \_\_\_\_\_

Drug: \_\_\_\_\_ Date Prescribed: \_\_\_\_\_ Reason: \_\_\_\_\_

Drug: \_\_\_\_\_ Date Prescribed: \_\_\_\_\_ Reason: \_\_\_\_\_

Are these drugs being prescribed by a physician? Yes No Last visit: \_\_\_\_\_

If you were previously taking any other medication regularly, please describe: \_\_\_\_\_

Do you or did you work with any chemical, fume, dust, powder, or smoke for prolonged periods? Yes No

Please explain: \_\_\_\_\_

**Is there anything else you wish to share, which has not been discussed, that may help us to better understand you and why you have chosen to see the doctor in this office?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Privacy Notice Agreement**

### **Patient consent for use and/or disclosure of protected health information to carry out treatment, payment, and healthcare operations.**

With my signature below, I give consent for Realigning the Soul (the Practice) to use and/or disclose information about me (or for whom I have legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and healthcare operations.

I have reviewed that Privacy Policy of this Practice prior to signing this consent. The Privacy Policy may be amended from time to time, and **I may always obtain a copy of the current policy by request.**

I have the right to request restrictions on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operation. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which it has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me including any invoices for services, reminder cards, birthday cards, newsletters, and the like, at the address/phone number/fax number/email address designated in my registration forms.

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PRINTED NAME OF PATIENT

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SIGNATURE OF PATIENT

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DATE