About You

Today's Date _____

Name _____
Last First M.I.

Birth date _____ Age____ SS#_____

Mailing Address _____

_____
City State Postal Code

Home Phone _____

Work _____

Cell or Pager _____

E-Mail Address _____

Referred By _____

Employer _____ How long? _____

Employer's Address _____

_____
City State Postal Code

Occupation _____

Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name _____

Do you have children? ☐ Yes ☐ No

How Many? _____

Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Other Physicians

Primary:

Name _____

Address _____

_____

Phone _____

Type of Physician _____

Other Physicians:

Name _____

Address _____

_____

Phone _____

Type of Physician _____

Condition _____

Name _____

Address _____

_____

Phone _____

Type of Physician _____

Condition _____

Name _____

Address _____

Type of Physician _____

Condition _____

Phone _____

In the Event of an Emergency

Who should we contact? _____

Relation _____

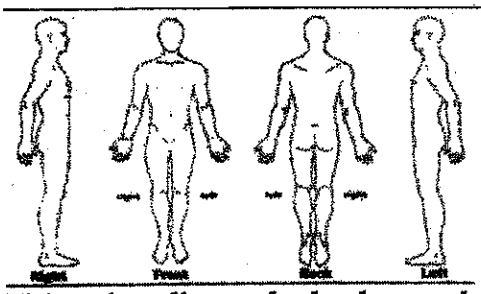
Home Phone _____

Work Phone _____

Cell or Pager _____

Reason For Visit

Reason for today's visit: □ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness
Are you in pain: □ Yes □ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: □ Work □ Sports/Play □ Auto Accident □ Routine/Household Activity
When did your accident occur? _____ Where did your injury occur? _____
Please explain what happened_____
Is your condition getting worse? □ Yes □ No □ Constant □ Comes and Goes
Is your condition interfering with your □ Work □ Sleep □ Daily Routine? If so, how_____
_____
Has this or something similar happened in the past?
□ Yes □ No Explain_____
_____



Using the adjacent body charts, please circle all affected areas.
Have you been treated by any other professional for this condition? □ Yes □ No If so where?_____
_____

Health History

Are you taking any of the following medications? □ Nerve Pills □ Pain Killers(including aspirin) □ Muscle relaxers □ Blood thinners □ Tranquilizers □ Insulin □ Other_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke
Y N Artificial Valves
Y N Shingles
Y N High/Low Blood Pressure
Y N Ulcers / Colitis
Y N Difficulty Breathing
Y N Heart Surg./ Pacemaker
Y N Alcohol / Drug Abuse
Y N Cancer
Y N Psychiatric Problems
Y N Fainting/Seizures/Epilepsy
Y N Chemotherapy
Y N Heart Murmur
Y N Venereal Disease
Y N Frequent Neck Pain
Y N Rheumatic Fever
Y N Sinus Problems
Y N Lower Back Problems
Y N Congenital Heart Defect
Y N Hepatitis
Y N Glaucoma
Y N Severe / Frequent Headaches
Y N Emphysema/ Asthma
Y N Mitral Valve Prolapse
Y N HIV+ / AIDS / ARC
Y N Anemia / Diabetics
Y N Artificial Bones/Joints/Implants
Y N Kidney Problems
Y N Tuberculosis
Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:_____
_____
List any past serious accidents with dates:_____
Please list anything you may be allergic to:_____
Family Health History:_____
Do you take Supplements or Vitamins? □ Yes □ No Do you exercise □ Yes □ No ____hours per week
Do you smoke? □ Yes □ No How much? _____ For How long? _____

Are you wearing □ Shoe lifts □ Inner Soles □ Arch Supports Are you dieting? □ No □ Yes Since_____
For Women: Are you taking birth control? □ Yes □ No
Are you Nursing? □ Yes □ No Are you pregnant? □ No □ Yes If so how many weeks_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly , mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit. We accept cash, check or all major credit cards.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date_____

"the power of innovative healing"

Informed Consent for Care

Print Full Name _____ Date_____

1. All the various modalities delivered at the center are simple, safe, noninvasive and natural method of normalizing the transmission of energy flows in the body and stress reduction. This is not a method for preventing, diagnosing, treating, healing, relieving or curing symptoms, disease or medical conditions of any kind. I understand that should I receive acupressure, exercise advice, diet advice, or nutritional device, there may be temporary side effects such as fatigue, flu-like symptoms and possible aggravation of the symptoms presented after a treatment. I agree not to wear perfumes or scented deodorants at the center, due to the potential of other client sensitivities. I also understand that being well fed and hydrated is necessary to facilitate benefits from our services and it is my responsibility to see that I have adequate nourishment each day._____
   Initials

2. I understand the practitioners are chiropractors, massage therapists, health coaches and personal trainers and there is no medical care provided of any kind. No cures are guaranteed. I understand that initial visit includes a history, exam and testing as directed in order to evaluate if the services of the center or right for me and determine if I am eligible for our services._____
   Initials

3. I understand that if I see a practitioner for an exam and initial consultation, that practitioner may not be my long-term practitioner. I understand that multiple practitioners may deliver the remainder of my care.
   _____
   Initials

4. I understand that Jeff Garner, D.C. may be my initial exam doctor and, if so, I may be turned over to another practitioner for the delivery of my program. I understand that should I desire a visit with Dr. Garner, it would be a special request, according to his availability and at his office visit rate (not debited from any Pre pay package or other visit rate, no complementary cards apply). There is no guarantee that Dr. Garner can fill this request. However, I do understand that Dr. Garner reviews client files if necessary. Should Dr. Garner *request* to see me during my visit or assist my practitioner during a visit, that the visit charge would be at the normal (or pre-pay) rate._____
   Initials

5. I understand that once nutritional supplements are purchased from and leave the office, they may not be returned, exchanged, refunded or credited unless the center determines that the order was filled incorrectly.
   _____
   Initials

6. **OFFICE FEES :**
   I Understand that the following center office visit fees apply:

   Initial consult (15 minute)-no charge
   Comprehensive initial exam $250.00

(Comprehensive consult and full testing. 24-hour cancellation or reschedule call is needed or fee is forfeited)
Treatment/program packages of 6 visits, 12 visits for 24 visits(program cost vary depending on type of case)
Chiropractic Adjustment- $115.00/visit
Chiropractic Adjustment done in conjunction with a treatment/program package- $115.00
Missed appointment charge (with no 24-hour advance notice) fee-$35
Bounce check he per incident (2 max. then cash only)-$35
Records copied fee.-$25/request (issued to client only, not sent to third party)
Monthly wellness program starting at $199 including 4 visits/month

7. **Should I opt to take advantage of it, I understand that the discounted, flat rate pre-per a package offered is a nonrefundable program and may not be altered, shared, transferred or combined with any other proportional special or discount.** I understand that any unused portion of a pre-pay package upon discharge from the center may be applied to product purchases or maybe move to another service pregnancy excluding complementary visits that were issued as part of a package rate) or is forfeited. I understand that I have one-year to use any free visits(3 visits can be used for office visit treatments, not products) or is forfeited. I understand that I am free to pay in full, visit by visit and at any prepay package program is only an incentive to move through my program to achieve my goals._____
Initials
8. **I understand that the Garner Health Center is paying cash at the time of service currently or in advance with discounted, prepay programs) or product purchases and that the center does no 3rd party or insurance billing, reporting, codeing, processing, or annual expense reporting of any kind whatsoever, this includes Doctor reports, records to insurance companies, insurance report forms, etc.) Postdated payments are not accepted.**_____
Initials
9. I have read and understand the above terms of service.

Patient signature_____ **Date**_____

10. **Consent to treat a minor (under 18 years old)**
I,_____, do hereby request the center to evaluate and perform services for my_____ named_____, age_____, and consent on his or her behalf. I am a legal guardian of this child. I understand that while this child is in the center, the child is to be with me at all times and may not be left alone, unsupervised or in the care of staff or other clients. I have read and agree to the centers above terms.
Guardian Signature_____ Date_____

Staff member_____ **Date** _____

7350 Senate Ave. Ste. A
Jersey Village, TX 77040
713-849-1373

Name: _____

Date: _____

Patient Evaluation Questionnaire

1. Please rate on the scale how serious you are about getting well. (circle number)

1 (Not Serious) 2 3 4 5 6 7 8 9 10 (Very Serious)

2. Would you prefer: (please circle)
   A. Temporary symptom relief
   B. Correction of cause of health problem

3. Are you willing to follow a treatment program designed to help you return to health for at least four months? (treating the cause)
   A. Yes
   B. No

4. Are you willing to make dietary changes if needed?
   A. Yes
   B. No

5. Are you willing to start a moderate exercise program-if needed?
   A. Yes
   B. No

6. Please rate on the scale how serious you are about staying healthy after your initial intensive care. (circle number)

1 (Not Serious) 2 3 4 5 6 7 8 9 10 (Very Serious)

7. Are you familiar with Applied Kinesiology and/or Reflex Analysis?
   A. Yes
   B. No

8. Would you be interested in attending a free 1-2 hour symposium on the ways you can help to heal yourself faster?
   A. Yes
   B. No

9. Please rate your stress level on the scale. (circle number)

1 (No Stress) 2 3 4 5 6 7 8 9 10 (Total Stress)

Functional Methylation Questionnaire

Name: _____ Age: _____ Date: _____

List your top 3 health concerns

1. _____

2. _____

3. _____

Please circle the number that applies to the questions below 0 as least / never to 3 as frequent/always

Category 1				
Consistent mood swings	0	1	2	3
Feel especially good with dark greens in meals	0	1	2	3
Tendency towards depression	0	1	2	3
Struggled with infertility	0	1	2	3
High homocysteine	0	1	2	3
Cold hands and feet	0	1	2	3
Irritability	0	1	2	3
Low WBC counts or platelets	0	1	2	3
Hypothyroid	0	1	2	3
Frequent headaches	0	1	2	3

Category 2				
Irritability, shaky or nervous with missed meals	0	1	2	3
Low blood pressure	0	1	2	3
Depend on coffee to get going in the morning	0	1	2	3
Light headed with standing or if meals are skipped	0	1	2	3
Eating relieves fatigue	0	1	2	3
Crave salt	0	1	2	3
Afternoon headaches	0	1	2	3
Energy level drops in the afternoon	0	1	2	3
Lack of hunger in the morning	0	1	2	3

Category 3				
Muscle fatigue and/or weakness	0	1	2	3
Feel like energy cup is 1/2 full	0	1	2	3
Tired even after a good nights sleep	0	1	2	3
Poor mental endurance	0	1	2	3
Poor physical endurance	0	1	2	3
Poor recovery from sickness	0	1	2	3
Regular muscle soreness, especially with use	0	1	2	3

Category 4				
Sensitive to chemicals and smells	0	1	2	3
Gain weight easily even when eating well	0	1	2	3
Cancer runs in the family	0	1	2	3
Tendency to swelling in body and joints	0	1	2	3
Excessive inflammation	0	1	2	3
Brain fog after exposure to chemicals or pollutants	0	1	2	3
Noticeable variations in mental speed	Yes		No	

Category 5				
Tendency toward insomnia	0	1	2	3
Tendency toward anxiety	0	1	2	3
Significant PMS	0	1	2	3
Tendency toward extremism	0	1	2	3
Weight gain with birth control	0	1	2	3
Tendency to migraines	0	1	2	3
Irritability or inability to handle stress	0	1	2	3
Great focus and energy	0	1	2	3
Sensitive to stimulants (ie coffee, tea)	0	1	2	3
Always have to be busy and / or active	0	1	2	3

Category 6				
Feelings of tiredness even after many hours of sleep	0	1	2	3
Difficulty paying attention	0	1	2	3
Easy going and very adaptable	0	1	2	3
Lack of drive / motivation	0	1	2	3
Dependency on coffee	0	1	2	3
Lack of excitement	0	1	2	3
Generally laid back	0	1	2	3
Sleep easily and prefer lots of sleep	0	1	2	3
Mind tends to be a little slow	0	1	2	3

Category 7				
Cold hands and feet	0	1	2	3
Poor nail health	0	1	2	3
Tendency to wear socks in bed	0	1	2	3
Tip of nose is often cold	0	1	2	3
Must exercise to improve energy and brain function	0	1	2	3
High blood pressure	0	1	2	3
Heart attack and/or stroke common in my family line	0	1	2	3

Category 8				
Feelings of nervousness or panic for no reason	0	1	2	3
Feeling of a "knot" in stomach	0	1	2	3
Inability to turn off mind when trying to sleep or relax	0	1	2	3
Consistent worry	0	1	2	3
Disorganized or distacted attention	0	1	2	3
General state of overwhelmed	0	1	2	3
Feeling tense often	0	1	2	3

Dr. Jared Allomong

Functional Methylation Questionaire

Category 9				
Quick temper and easily overreact	0	1	2	3
Irritability	0	1	2	3
Headaches with Aged Cheese chocolate and wine	0	1	2	3
Struggle with addiction or extremes behaviors	0	1	2	3
Self - confident	0	1	2	3
Difficulty falling asleep	0	1	2	3
Rarely depressed	0	1	2	3

Category 10				
Sweet tooth	0	1	2	3
Crave carbs, sugar, and pastries	0	1	2	3
Tendency towards depression	0	1	2	3
Lack of self-confidence	0	1	2	3
Find myself apologizing all the time	0	1	2	3
Can't sleep through the night	0	1	2	3
Tendency to snack in the middle of the night	0	1	2	3

Category 11				
Reaction to wine / beer	0	1	2	3
Asthma	0	1	2	3
Itchy skin / Hives	0	1	2	3
Negative response to cleansing	0	1	2	3
Sulfa drug allergy	Yes		NO	

Category 12				
Feel more down in the Fall and Winter	0	1	2	3
Have known autoimmune condition	Yes		NO	
Catch colds or flu easily	0	1	2	3
Slow healer	0	1	2	3
Always wear sunscreen or avoid direct sunlight	0	1	2	3

Category 13				
Can't handle shellfish	0	1	2	3
Alcohol makes me feel ill	0	1	2	3
Have headaches often	0	1	2	3
Fequent heartburn	0	1	2	3
Feel bloated after many foods	0	1	2	3
Skin reactions like hives or eczema	0	1	2	3
Struggle with asthma or exercise induced asthma	0	1	2	3
Feel better on an anti-histamine	0	1	2	3
Joints frequently hurt	0	1	2	3
Felt better during pregnancy	0	1	2	3

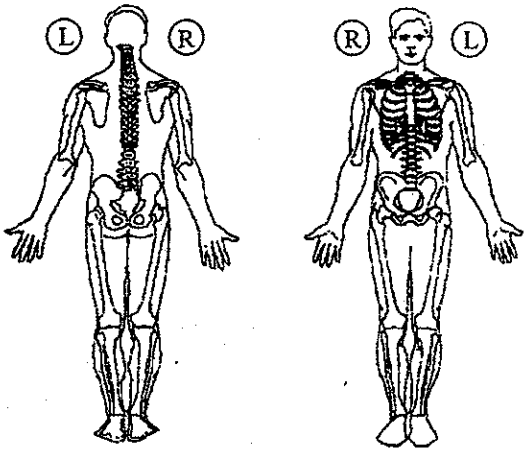
Category 14				
Need more than 8 hours of sleep	0	1	2	3
Feel mentally foggy or slow	0	1	2	3
Muscle pain regularly especially with activity	0	1	2	3
Gallbladder problem / dietary fat intolerance	0	1	2	3
Vegan /vegetarian	0	1	2	3
Pain in many area of the body	0	1	2	3
Experience memory lapses	0	1	2	3
High cholesterol or fatty liver disease	0	1	2	3
Slow mental recall	0	1	2	3

Current Medications:_____

Current Supplements:_____

Print Name: _____ Date: _____

Directions: **Shade the EXACT area where you are having symptoms at this time. List the severity of symptoms:** MILD, MODERATE, SEVERE Pain (PN), numbness (NB), tingling (T), stiffness (STF), swelling (SW), discomfort (DS), spasms (SP), Aching (A), cramping (CR), shooting (SH), dull (D), sharp (SR).



For Clinical and Legal purposes, areas must be shaded or you will not be treated.

Pulse:_____ BP:_____ WT:_____

Answer the following questions:

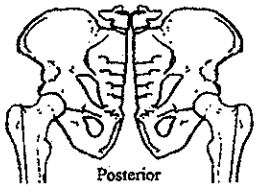
1. After my last treatment, I felt:
   Better, Same, Worse
   Relief lasted _____ Hours _____ Days
2. Describe any new or worse symptoms or injuries.
   _____
   _____
3. Blood Pressure Declined ☐
4. The care has been: Poor Good Excellent

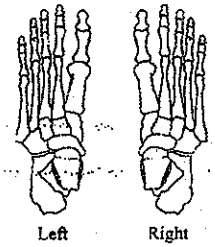
X _____
Patient's Signature

DX & Comments

L Vertebral R Fixations on Palpation

SP	INFL		INFL	SP
		OCC		
		C1		
		C2		
		C3		
		C4		
		C5		
		C6		
		C7		
		T1		
		T2		
		T3		
		T4		
		T5		
		T6		
		T7		
		T8		
		T9		
		T10		
		T11		
		T12		
		L1		
		L2		
		L3		
		L4		
		L5		





Modality	Area	Time	Intensity
JM/ADJ			
Extraspinal			
TPT			
NMR 15-30			
ESTIM / IR / Vaso			
IFC/EMS			
Cold Laser			
Exercise			
IST/F.D.			
HP/ICE			
PCLT / CLT			
Massage 30-60			
Dry Needling			

EVALUATION AND MANAGEMENT

S64	New Intermediate Eval.
S65	New Extended Eval.
S66	New Comprehensive Eval.
S69	Est. Intermediate Eval.
S70	Est. Extended Eval.
S71	Est. Comprehensive Eval.

MANIPULATION

S137	Spinal 1-2 regions
S138	Spinal 3-4 regions
S146	Extraspinal 1 or more regions
S107	Trigger point therapy

Plan:

EXAM	L/R
Cerv. Comp.	/
Cerv. Dist.	/
Spurlings	/
Adson's	/
Solo-Hall	/
Biceps Rflx.	/
Triceps Rflx.	/
Patellar Rflx.	/
Achilles Rflx.	/
Valslva	/
SLR	/
Kemps (lumbar)	/
Braggards	/
Lewin	/
George's	/
Ely's	/
Carpal Tunnel	/
Derifield	/

MODALITIES

S23	Traction, mechanical
S114	Electrical therapy, attended
S129	Electrical therapy, unattended
S106	Ultrasound
S86	Flexion, Distraction
S167	PolyChromatic Light Therapy
S120	Vasopneumatic
S198	Cold Laser Therapy
S114 S119 S120	PEMF Simulcare MTS

ORTHOTICS/TRAINING

S29	Neuromuscular Re-education
S32	Massage 30 min. or 60 min.
S164	Home Instructions
S28	Therapeutic Exercises 15 min.
S119	Kinetic Training

Pain Grade LT	Muscle Spasms	RT Grade Pain
	TMJ	
	Sub-Occ	
	Post Neck	
	Trapezius	
	Levator Scapula	
	SCM	
	Scalene	
	Pectoral	
	Intercostals	
	Rotator Cuff	
	Rhomboid	
	Erectors	
	Spinalis	
	Multifidi	
	Quad Lumb	
	Gluteus	
	Piriformis	
	Biceps Fem	
	Popliteus	
	TFL	
	Hip Flexor	
	Psoas	
	Iliacus	
	Gastroc	
	Achilles	
	Plantaris	

Cervical ROM	Normal	Degrees
Flexion	40° to 60°	
Extension	60° to 70°	
Left lateral flexion	20° to 45°	
Right lateral flexion	20° to 45°	
Left rotation	70° to 80°	
Right Rotation	70° to 80°	
Lumbar ROM		
Flexion, Distance Floor to fingertip	40° to 60°	
Extension	20° to 35°	
Left lateral flexion	20° to 30°	
Right lateral flexion	20° to 30°	
Left Rotation	25° to 45°	
Right Rotation	25° to 45°	

Total Fee: _____

Req. Payment: _____

Payment Rec'd: _____

Balance: _____

_____
Doctor's Signature

Next Appointment: M T W T F S

← See comments on back →

Authorization to Send and Receive Medical Information by Email/Text

Memorial Chiropractic Clinic (the "Practice") sends patient information by e-mail and/or text messaging.

RISKS: Transmitting information by e-mail/text, however, has a number of risks that patients should consider before using e-mail/text (the "Risks"). These include, but are not limited to, the following Risks:

1. E-mail/text can be circulated, forwarded, and stored in numerous paper and electronic files.
2. E-mail/text can be immediately broadcast worldwide and be received by many intended and unintended recipients.
3. E-mail/text senders can easily misaddress an e-mail or text.
4. E-mail/text is easier to falsify than handwritten or signed documents.
5. Backup copies of e-mail/text may exist even after the sender or the recipient has deleted his or her copy.
6. Employers and on-line services have a right to archive and inspect e-mails/texts transmitted through their systems.
7. E-mail/text can be intercepted, altered, forwarded, or used without authorization or detection.
8. E-mail/text can be used to introduce viruses into computer systems.
9. E-mail/text can be used as evidence in court.

CONDITIONS: Because of the Risks outlined above, the Practice cannot guarantee the security and confidentiality of e-mail/text communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by the Practice's intentional misconduct. Thus, patients must consent to the use of e-mail/text for patient information. Consent to the use of e-mail/text includes agreement with the following conditions:

1. All e-mails/texts to or from the patient concerning diagnosis or treatment will be saved as part of the medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails/texts.
2. The Practice may forward e-mails internally to the Practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. The Practice will not, however, forward e-mail to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although the Practice will endeavor to read and respond promptly to an e-mail/text from the patient, the Practice cannot guarantee that any particular e-mail/text will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail/text for medical emergencies or other time-sensitive matters.
4. If the patient's e-mail/text requires or invites a response from the Practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail/text and when the recipient will respond.

5. The patient should not use e-mail/text for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
6. The patient is responsible for informing the Practice of any types of information the patient does not want to be sent by e-mail/text, in addition to those set out in the preceding paragraph.
7. The patient is responsible for protecting his/her password or other means of access to e-mail/text.
8. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.
9. The Practice shall not engage in e-mail/text communication that is unlawful, such as unlawfully practicing medicine across state lines.
10. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS: To communicate by e-mail/text, the patient shall:

1. Limit or avoid use of his/her employer's computer.
2. Inform the Practice of changes in his/her e-mail address or text number.
3. Put the patient's name in the body of the e-mail/text.
4. Include the category of the communication in the e-mail's subject line or body of a text message, for routing purposes (e.g., billing question).
5. Review the e-mail/text to make sure it is clear and that all relevant information is provided before sending to the Practice.
6. Inform the Practice that the patient received an e-mail/text from the Practice.
7. Take precautions to preserve the confidentiality of e-mails/texts, such as using screen savers and safeguarding his/her computer password.
8. Withdraw consent only by e-mail or written communication to the Practice.
9. Contact the Practice's Privacy Official at (713) 467-5367 with any unanswered questions before communicating with the Practice via e-mail or text message.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the Practice has provided me regarding the Risks of using e-mail and text messaging. I understand the risks associated with the communication of e-mail and text between the Practice and me, and consent to the conditions outlined in this document. In addition, I agree to the instructions outlined above, as well as any other instructions that the Practice may impose regarding e-mail or text message communications.

Signature of patient or personal representative _____ Date _____

Printed name of patient or personal representative _____ Phone number to be used for sending medical records _____

E-mail address authorized to be used for sending medical records _____