Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Personal Contact Information **Today's Date** _____

Name_____ Age_____Date of Birth _____
Address _____ City _____ State _____Zip Code _____
Home Phone_____ Height _____ Weight_____ Sex (Circle one): M F
Work Phone _____ Employer_____
Cell Phone_____ Occupation _____
Email _____
Marital Status (Circle one): Single Partnered Married Divorced Widowed Number of Children____
Emergency Contact: Name _____Phone _____
Relationship to Patient _____

Medical History

Do **You** have any history of (Check all that apply):

❑ Heart disease ❑ Cancer ❑ Stroke ❑ Diabetes
❑ Hypertension ❑ Low blood sugar ❑ Low blood pressure ❑ Liver disease
❑ Dementia ❑ Alzheimer's ❑ Parkinson's ❑ Concussion
❑ Head injury ❑ Depression ❑ Mental illness ❑ Other _____

Elaborate on any **Family** history of the above:_____

_____

_____

Have you ever had any broken bones? ❑ Yes ❑ No
Which bone(s) and when? _____
Any long-term effects? _____
Have you ever had any surgeries? ❑ Yes ❑ No
Please list any surgical procedures and their respective dates: _____

_____

When was your last physical exam? _____
Results:_____

_____

Results of latest lab work? _____

Nutrition and Exercise History

Do you smoke? ❑ Yes ❑ No
Have you ever smoked? ❑ Yes ❑ No If Yes, Cessation date _____
Do you drink Alcohol? ❑ Yes ❑ No If Yes, How much and how often? _____
Are you a Vegetarian? ❑ Yes ❑ No If Yes, What kind? _____
How many meals do you eat per day?_____How often do you eat out? _____
What type of food do you eat when eating out? _____
Do you exercise regularly? ❑ Yes ❑ No If Yes, What kind of exercise and how often? _____

_____

List all medications, vitamins and supplements that you are currently taking: _____

_____

_____

Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

History of Present Illness

Describe the symptoms that you are experiencing, their location(s), and types of pain:_____

_____

_____

_____

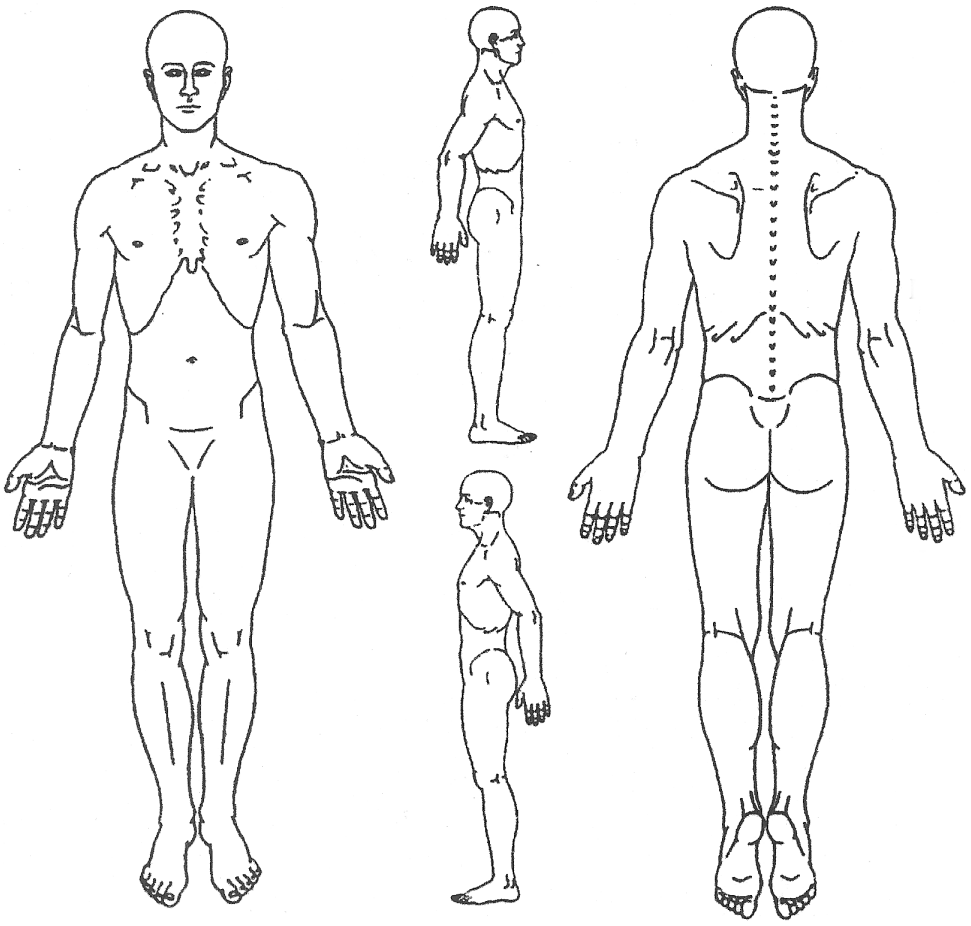
_____

When did you first notice these symptoms?_____

Has this happened before? (Circle one) Yes No If Yes, When? _____

Mark the areas where you feel the described sensations on the pictures below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
---------	00000	XXXXX	*****	//////



Neck - Shoulder - Arm Pain

On a scale of zero to ten,
I rate my discomfort as follows:

0 ⟷ 10

No pain Severe pain

Mid Back Pain

On a scale of zero to ten,
I rate my discomfort as follows:

0 ⟷ 10

No pain Severe pain

Low Back and Leg Pain

On a scale of zero to ten,
I rate my discomfort as follows:

0 ⟷ 10

No pain Severe pain

Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Was the pain caused by (Check all that apply):

- ❑ Strain, Date of strain_____
- ❑ Fall, Date of fall _____
- ❑ Mental Stress
- ❑ Emotional Stress
- ❑ Auto accident, Date of accident_____

Is this a work related accident (Circle one)? Yes No

We are not a worker's compensation provider under the State of Texas and therefore are unable to treat any work related injuries.

Have you seen another doctor for this (Circle one)? Yes No
Name of Doctor: _____City: _____ X-Rays_____
Treatment:_____ MRI _____
Results_____ CAT Scan _____
_____
_____

If you have copies of any films or imaging reports that relate to what you are seeking treatment for, please provide these documents to our office.

Are you still under this doctor's care (Circle one)? Yes No
When was your last physical? _____Results_____
Please list any other information that you feel may be pertinent:_____
_____
_____
_____
_____
_____
_____

How Did You Hear About Us?

Were you referred by (Check all that apply):

- ❑ Another patient, Name of Patient_____
- ❑ Yellow pages ad
- ❑ Austin All Natural Magazine
- ❑ Website, Name of Site _____
- ❑ Other, _____

Please read the following statements carefully and sign after each statement to indicate your understanding and acceptance of our office policies.

Auto PIP:

We will accept assignment on all Auto Insurance PIP plans, EXCEPT *ALLSTATE*. We file the necessary paperwork and are paid directly by your PIP Insurance carrier. Please provide all policy information for us to file your claim (i.e. your insurance company contact information, claim number, etc…).

_____ _____ _____

Signature of Patient (or Guardian if under 18 years old) Relationship to Patient Today's Date

Health Insurance:

This office is not under contract with any health insurance plans, therefore, we are not able to file your claim or be paid directly by your insurance company. We are considered an "out-of-network" provider on all/most PPO plans, therefore your insurance company should reimburse you for your treatment up to the allowable percentage after your deductible. You will be responsible for paying your bill in full as services are rendered, and you will be provided an itemized receipt sufficient for your insurance purposes. HMO Plans require that you go to doctors on their list, therefore you will not be reimbursed for your visit here. We Accept, VISA, MASTERCARD, AMEX and DISCOVER CARD for your convenience.

_____ _____ _____

Signature of Patient (or Guardian if under 18 years old) Relationship to Patient Today's Date

Medicare:

While we do not accept assignment on Medicare and cannot be paid directly by Medicare, we will file your claim to Medicare as a courtesy to you. Medicare should reimburse you for your treatment up to the allowable percentage after your deductible. You will be responsible for paying your bill in full as services are rendered. Please provide us with your Medicare card so we can make a copy of it.

_____ _____ _____

Signature of Patient (or Guardian if under 18 years old) Relationship to Patient Today's Date

Worker's Comp:

We are no longer a worker's compensation provider under the State of Texas and therefore we are unable to treat any work related injuries until you are release from said worker's comp claim.

_____ _____ _____

Signature of Patient (or Guardian if under 18 years old) Relationship to Patient Today's Date

Cancellation Policy:

In order to avoid a $65 Missed Appointment Fee, we require a **2 Hour Notice** if you need to cancel your appointment.

_____ _____ _____

Signature of Patient (or Guardian if under 18 years old) Relationship to Patient Today's Date

Treatment Room Policies:

Only the patient is allowed in the room with the doctor, with the exception of small children or extenuating circumstances requiring the presence of another person. We make those determinations on a case-by-case basis. In order to better know you and your family, we welcome your child(ren) in our office. However, we find that the nature of our hydraulic equipment poses a safety hazard. Therefore we ask that you bring someone with you to watch your child(ren) in the waiting area while you are receiving your treatment.

_____ _____ _____

Signature of Patient (or Guardian if under 18 years old) Relationship to Patient Today's Date