INTRODUCTION PATIENT CASE HISTORY

Today's Date: ______________

PATIENT INFORMATION

Name: *(First MI Last)* ____ **Preferred Name**: __________________

Address: ____________________________ **City:** ________________________ **State:** _______ **Zip:** ___________

Home: _________________ **Mobile:** __________________ **Mobile Carrier:** ____________________ **Work:** _________________

Email: ____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #:___________________________________ **Date of Birth:** _____________________________________

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: __________

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

***Referred By:** (*Name*): ______________________________ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* ___________________________________ **Primary Care Physician:** ____________________________

Home: __________________ **Mobile:** __________________ **Doctor's Phone:** ____________________________________

Relationship: Child / Parent / Spouse / Other: ____________

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay *(Cash)* ☐ Personal Injury/Auto ☐ Other *(please explain)*:_________________________

PRIMARY INSURANCE

Insurance Name: ____________________________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____________________ **Gender:** M / F

Address: ____

City: ___________________ **State:** _____ **Zip:** _________

Phone: __________________ **Date of Birth:** ___________

SECONDARY INSURANCE

Insurance Name: ____________________________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____________________ **Gender:** M / F

Address: ____

City: ___________________ **State:** _____ **Zip:** _________

Phone: __________________ **Date of Birth:** ___________

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - *(Relationship)* ______________________________________

Other than Self:

Name: *(First MI Last)*____

Address: ____ **City:** _________________ **State:** _______ **Zip:** ___________

Phone: ____________________ **Email:** _______________________________________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: ___________

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ______________________________

Describe any Secondary Complaints: ______________________________

Describe WHEN and HOW this began: ______________________________

____

____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: ______________

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* ______________

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* ______________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ______________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ______________

Which daily activities are being affected by this condition? *(Describe)* ______________

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: ________ **Where?** ________
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: ________ **When and Where?** ________

HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

Medications and Supplements:

Allergies to Medications: *NONE*

Name	Reaction

Current Medications & Supplements: *NONE*

Name	Dosage	Frequency	Method

Past Health History: *(Please list any past…)*

Number of Falls in the last 24 months: _____**Injuries?** Y or N

Surgeries: *NONE*

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: *NONE*

Date	Describe

Family Health History: *N/A*

List *relevant* major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

Patient No: ___________

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Are you *currently* experiencing any of these symptoms? *(Check all the apply)*

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems ________________
- ☐ Leg Problems ________________
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones________________
- ☐ Other: ______________________
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: ______________________
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ______________________
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: ______________________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ______________________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: ______________________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: ________________
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: ______________________
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: ______________________
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: ______________________
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes -** ***Due Date*** ___/____/____
- ☐ **No -** ***Last Menstrual Period*** ___/____/____

- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

Comments: ____

____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature ____ Date________________

Treating Doctor Signature ____ Date________________

Patient No: ___________

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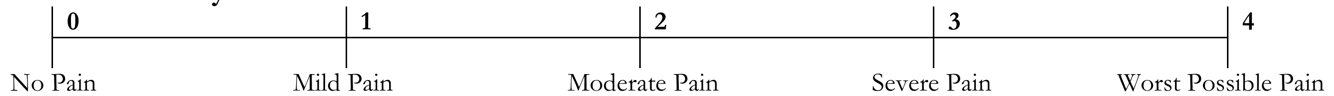
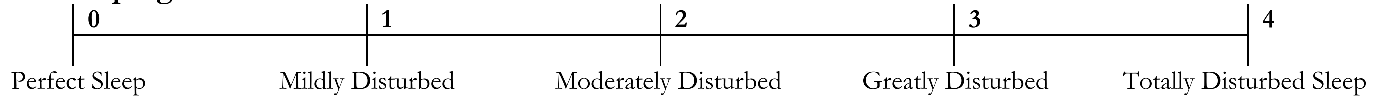
Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

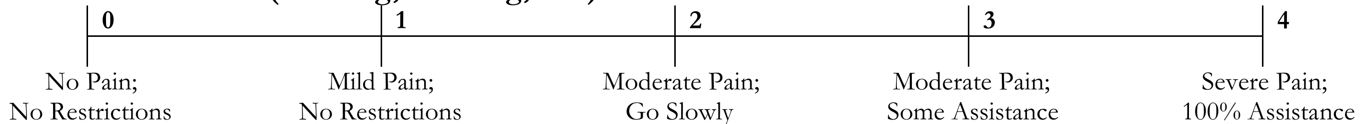
1. Pain Intensity



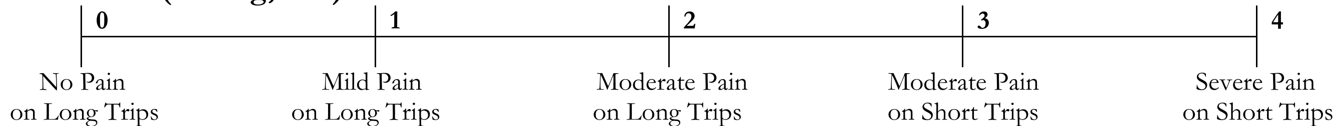
2. Sleeping



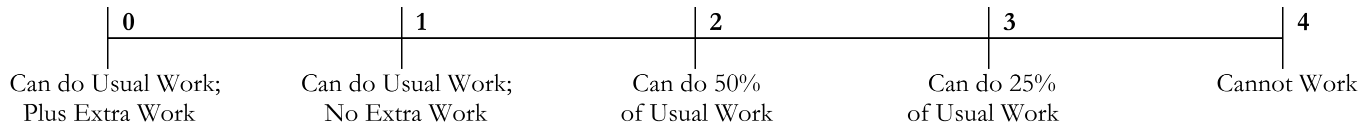
3. Personal Care (washing, dressing, etc.)



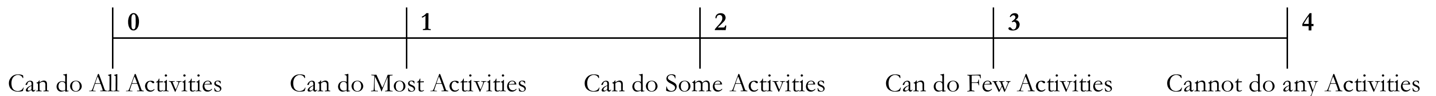
4. Travel (driving, etc.)



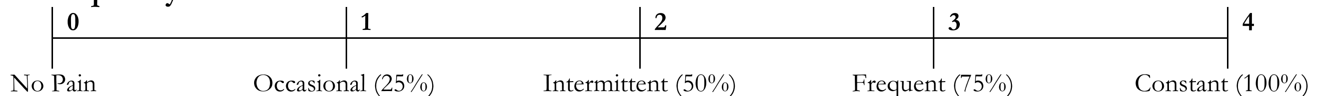
5. Work



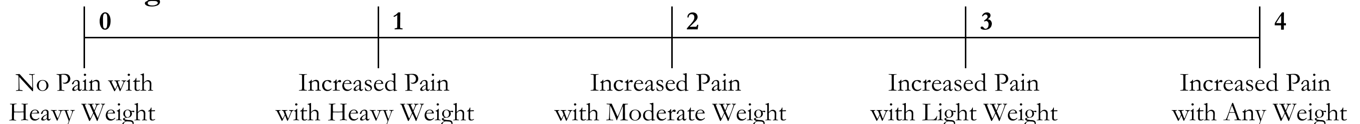
6. Recreation



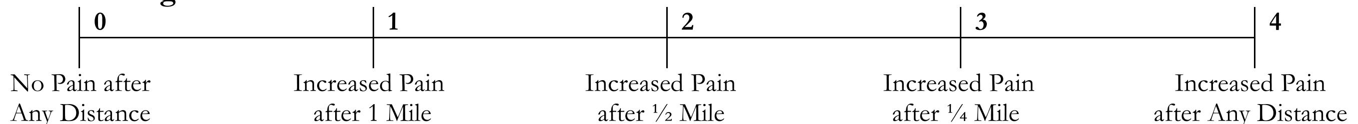
7. Frequency of Pain



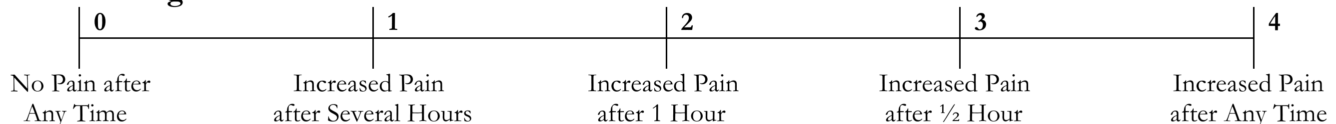
8. Lifting



9. Walking



10. Standing



Patient or Guardian Signature: X____ Date: ______________

Functional Rating Index Total Score:__________% (To be completed by Doctor's office.)

Austin Chiropractic & Acupuncture Clinic

Dr. Justin Swanson, D.C., F.A.S.A., C.C.E.P.

6101 Balcones Drive, Suite 102, Austin, Texas, 78731

Phone: 512.452.2525   Fax: 512.452.0505

Patient Name: ____ D.O.B.: ______________Date:______________

Before this office begins any health care procedures we require you to read and sign this form stating you understand the below items. In the event you refuse to sign this form, the provider reserves the right to refuse care.

AUTHORIZATION: By signing below you authorize this office/provider to complete a consultation and examination for the above named patient.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you consent to the taking of x-rays if there is a determined need. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you have declared, to the best of your knowledge, there is no chance you are pregnant at this time.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you further acknowledge understanding that your health and motor vehicle insurance policies are an agreement between you and your carrier, and you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, (e.g. insurance company, attorney, etc.). By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office. **I instruct checks to be made payable to Dr. Justin Swanson, and payment to be sent to 6101 Balcones Drive, Suite 102, Austin, Texas, 78731.**

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state “Signature On File” or “SOF”. Box 12 Reads as follows: “PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.” Box 13 Reads as follows: “INSURED’S OR AUTHORIZED PERSON’S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below.”

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below you authorize this office to contact you for office related matters in the following manner: telephone (home, mobile, work), mobile text messaging, e-mail and postal mail. Messages may be left on an answering device/voicemail, or with the person answering your telephone. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), updated September 23, 2013, this office is required to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: examinations, chiropractic adjustments, supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify all the information given to this office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Patient Signature: X____ Date: ____________________

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6101 Balcones Drive, Suite 102, Austin, Texas, 78731
Phone: 512.452.2525 Fax: 512.452.0505

Patient Name: ____ D.O.B.: ______________Date:______________

CONSENT FOR CHIROPRACTIC SERVICES

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (spinal manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (arms, legs, etc.), often resulting in an audible sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the or by staff under the chiropractor's direction or supervision incorporating the use of motion, electricity, traction, heat, cold, bracing, or nutritional advice;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: X____ Date: ____________________

Witness Signature:X____ Date: ____________________