# Austin Chiropractic & Acupuncture Clinic

6101 Balcones Drive, Suite 102
Austin, Texas 78731
512-452-2525

## Patient Information

**Date:**_____

**Patient Name** (Legal):_____ **Date of Birth:**_____/_____/_____

**Preferred Name** (If Any):_____ **Social Security No.:**_____-_____-_____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**E-Mail Address:**_____ **Home Phone:**_____

**Mobile Phone:**_____ **Preferred Method of Contact:** ☐ **Phone Call** ☐ **Text Message** ☐ **E-Mail**

**Occupation:**_____ **Employer:**_____

**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Partnership** ☐ **Divorced** ☐ **Widowed**

**Spouse's Name:**_____ **Number of Children:**_____ **Age of Children:**_____

**Emergency Contact:**_____ **Contact Phone:**_____

**Medical Doctor:**_____ **Clinic Name:**_____

**Have you ever received Chiropractic Care?** ☐ **No** ☐ **Yes, Doctor's Name:**_____

**Who can we thank for referring you for care?** _____

# Patient Case History

**Major Complaint**(s):_____

**Complaint Began When and How?** _____

**Grade Intensity/Severity of Complaint/Pain:** [None] **0 1 2 3 4 5 6 7 8 9 10** [Worst Possible]

**What Daily Activities are affected by the Complaint?** _____

**Previous Treatment:** ☐ **None** ☐ **MD** ☐ **PT** ☐ **Massage** ☐ **Heat** ☐ **Ice** ☐ **Meds** ☐ _____

**Quality of Complaint/Pain:** ☐ **Sharp** ☐ **Stabbing** ☐ **Shooting** ☐ **Numbness** ☐ **Tingling** ☐ **Weakness** ☐ **Gripping** ☐ **Burning** ☐ **Throbbing** ☐ **Stiffness** ☐ **Soreness** ☐ **Tenderness**

**Frequency of Complaint/Pain:** ☐ **Off & On** ☐ **Constant** **When is Complaint/Pain the worst?** ☐ **AM** ☐ **PM**

**Does the Complaint/Pain Radiate to Any Part of your Body?** ☐ **No** ☐ **Yes, Where to?** _____

**What Makes it Better?** ☐ **Nothing** ☐ **Rest** ☐ **Ice** ☐ **Heat** ☐ **Movement** ☐ **Stretching** ☐ **Meds** ☐_____

**What Makes it Worse?** ☐ **Rest** ☐ **Sitting** ☐ **Standing** ☐ **Movement** ☐ **Overuse** ☐ **Stress** ☐_____

**Secondary Complaint**(s) (If Any):_____

**What are your goals for care in our office?** ☐ **Short-term Relief** ☐ **Long-term Relief** ☐ **Wellness/Preventive Care**

**Current Medications:**

☐ **None**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Past Health History – Major Injuries/Traumas:**

☐ **None**

_____ _____
_____ _____
_____ _____

**Past Health History - Surgeries/Hospitalizations:**

☐ **None**

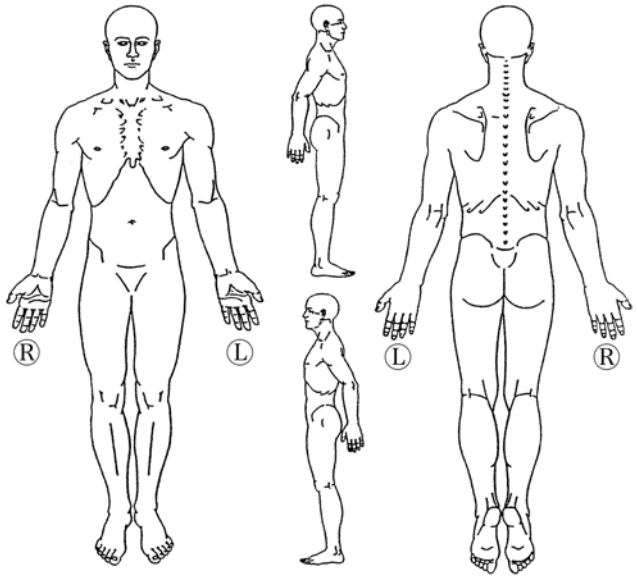
_____ _____
_____ _____
_____ _____

**Family Health History - Relavent First Degree Relatives:**

☐ **None**

_____ _____
_____ _____
_____ _____

**MARK DIAGRAM WITH LOCATION OF COMPLAINTS**




**Lifestyle & Social History:**

**Current Use:** ☐ **Caffeine** ☐ **Tobacco** ☐ **Marjiuana** ☐ **Alcohol** ☐ **Recreational Drugs**

**Hobbies:**_____
**Recreation:**_____
**Exercise:** _____
**Diet:** _____

**Are you *currently* experiencing any of these symptoms?** (Check all that apply)
**Many of the following conditions respond to Chiropractic and Acupuncture care.**

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

**Musculoskeletal:**
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back 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

**Cardiovascular & Heart:**
- ☐ Chest Pains
- ☐ Rapid Heartbeat or Other 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

**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

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

**Endocrine, Hematologic, & 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

**Eyes & Vision:**
- ☐ Wear Contacts/ Glasses
- ☐ Blurred or Double Vision
- ☐ Glaucoma
- ☐ Eye Disease or Injury
- ☐ Other: _____
- ☐ None in this Category

**Ears, Nose & 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

**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

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Patient Signature: X_____ Date: _____

Doctor Signature: X_____ Date: _____

# Functional Rating Index

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

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

## 1. Pain Intensity

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain |

## 2. Sleeping

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect Sleep | Mildly Disturbed Sleep | Moderately Disturbed Sleep | Greatly Disturbed Sleep | Totally Disturbed Sleep Sleep |

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

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain; No Restrictions | Mild Pain; No Restrictions | Moderate Pain; Need To Go Slowly | Moderate Pain; Need Some Assistance | Severe Pain; Need 100% Assistance |

## 4. Travel (driving, etc.)

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain on Long Trips | Mild Pain on Long Trips | Moderate Pain on Long Trips | Moderate Pain on Short Trips | Severe Pain on Short Trips |

## 5. Work

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do Usual Work; Plus Extra Work | Can do Usual Work; No Extra Work | Can do 50% of Usual Work | Can do 25% of Usual Work | Cannot Work |

## 6. Recreation

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do All Activities | Can do Most Activities | Can do Some Activities | Can do Few Activities | Cannot do Any Activities |

## 7. Frequency of Pain

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain | Occasional Pain; 25% of the Day | Intermittent Pain; 50% of the Day | Frequent Pain; 75% of the Day | Constant Pain; 100% of the Day |

## 8. Lifting

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain with Heavy Weight | Increased Pain with Heavy Weight | Increased Pain with Moderate Weight | Increased Pain with Light Weight | Increased Pain with Any Weight |

## 9. Walking

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain after Any Distance | Increased Pain after 1 Mile | Increased Pain after ½ Mile | Increased Pain after ¼ Mile | Increased Pain with All Walking |

## 10. Standing

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No Pain after Several Hours | Increased Pain after Several Hours | Increased Pain after 1 Hour | Increased Pain after ½ Hour | Increased Pain with Any Standing |

Patient Signature: X_____ Date: _____

Functional Rating Index Score: _____% (Completed by Dr. Swanson.)

# Austin Chiropractic & Acupuncture Clinic, P.C.
## 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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**Phone: 512.452.2525 Fax: 512.452.0505**


Patient Name: _____ D.O.B.: _____ Date: _____

**INFORMED CONSENT FOR CHIROPRACTIC SERVICES**

**I have been informed of the following:**

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 (ribs, arms, legs, etc.), often, but not necessarily, resulting in an audible pop or clicking sound;
2. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of motion, electricity, traction, bracing, heat, cold, or nutritional/lifestyle recommendations;
3. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury. The possible consequences and possible complications have been explained to me by the chiropractor;
4. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
5. I have been informed that certain techniques may require close proximity between clinician and patient;
6. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
7. I have been afforded ample opportunity for questions and answers; and
8. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations.

**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: _____