

Family Chiropractic Center, Inc.
4201 Bee Cave Road
Suite C212
Austin, Texas 78746
(512) 347-8033
www.famchiro.com

We want to welcome you to the Family Chiropractic Center.

Our goal is to provide for your health needs through the use of modern chiropractic and natural health techniques. We look forward to serving you.

Our office is located in the Schoolyard, an office park just west of Eanes Elementary School on Bee Cave Road. Suite C212 is in Building C, at the back of the complex.

Please arrive wearing comfortable, loose-fitting clothing and allow up to 90 minutes for your initial appointment.

Attached you will find a "Patient History". Please print and complete it. This will allow us to focus your examination on the matters of maximum importance to you. Bring your history along with a photo ID and your insurance card to your first visit.

An acknowledgment of our "Privacy Policies & Consents" is included at the end of the history. A complete version of these policies is either included as a separate file or is available on our website. Please review the complete document prior to signing the acknowledgement.

If you have any questions prior to your appointment, please call or email info@famchiro.com.

Supporting your well being,

Family Chiropractic Center Doctors and Staff



CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Nickname:		Date:	
Address:					
Home phone:			Work phone:		
Cell phone:			Email address:		
Best time/place to contact you:					
Best way to confirm appointments: Email <input type="checkbox"/> Text <input type="checkbox"/> Cell Phone Provider:					
Date of birth:			Age:		
No. of children:			Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Height:			Weight:		
Marital status: M S W D			Spouse/guardian name:		
Occupation:					
Employer's name & address:					
Spouse's Occupation/Employer:					
Emergency Contact:			Phone:		
Do you have insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>			Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Insurance Company:					
Insurance Policy number:			Insurance phone number:		
Insurance Group number:					

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain):

Which activities aggravate your condition? _____

Have you had previous chiropractic care? Yes No Dr: _____ Date of Last Treatment: _____

Other Doctors You Have Seen For This Condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
-------------------------------	--------------------------------	--	--	--

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?
2. Type:	When?
3. Type:	When?
4. Type:	When?

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
---------------	-------	--------

Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. _____
- b. _____
- c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. _____
- b. _____
- c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- a. _____
- b. _____
- c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
----------	----------	----------

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
----------------	------------------	--------	-----------------	-----------

How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
------------------------------------	-------------------------------	-------------------------------	-------------------------------	---	--

How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
------------------------------------	-------------------------------	-------------------------------	-------------------------------	---	--

Is there anything else which may help to better understand you, which has not been discussed?

Why are you here at this point in time?

Indicate Your Desired Outcomes As a Result of Your Care in Our Office:

- Reduce Pain No Residual Pain Minimal Activity Limitations No Activity Limitations
Future Recurrence Minimized Condition Fully Resolved Lifestyle Changes to Prevent Recurrence

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient / Parent / Guardian Name: _____ Date: _____

Signature: _____

Acknowledgement for Use and Disclosure of Protected Health Information and Consents to Chiropractic Evaluation, Treatment and Financial Policies

Notice of Privacy Practices I have read and understand the Family Chiropractic Center, Inc. Notice of Privacy Practices; **“Your Information. Your Rights. Our Responsibilities”** as well as “Informed Consents” which describe how my Protected Health Information may be used or disclosed. I understand that I may request a copy of the Notice at the Front Desk or view it at www.famchiro.com.

Informed Consent and Authorization for Chiropractic Evaluation and Treatment: I understand that although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, there are possible risks and complications associated with these procedures. I have read and understood the description of common risks associated with these procedures. I hereby authorize the doctors of FCC to perform the history, diagnostic and examination procedures they deem necessary related to conditions presented in this office.

I understand that the doctors have the right to refuse or accept me as a patient at any time before treatment begins. Should they accept me for treatment, I give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that chiropractic procedures may consist of adjustments involving movement of the joints and soft tissues. Adjunctive physical therapy, exercises and nutritional therapy may also be used in my treatment. I understand that there may be additional risks associated with any of these forms of treatment. Should I have any adverse reactions to treatment, I will notify my doctor as soon as possible. I intend this consent to apply to all present and future chiropractic care received in this office.

Non-Covered Services Policy: I understand that some of the services or supplies I receive at Family Chiropractic Center may not be approved for reimbursement by insurance companies. If such is the case, I will be informed in advance of these items. Should I then choose to utilize these supplies or services, they will not be billed to my insurance company and will be my sole financial responsibility.

Informed Consent of Appointment Scheduling Policies If I discover that I am not able to make a scheduled appointment, I will notify Family Chiropractic Center, Inc. at the earliest possible opportunity. I understand that if I miss an appointment or fail to provide twenty-four hours notice prior to canceling or rescheduling an appointment, I will be responsible for paying for that appointment in full.

Authorization for Direct Payment to Family Chiropractic Center, Inc. Should I have an outstanding balance on my account with Family Chiropractic Center, Inc., I authorize direct payment of my medical benefits to Family Chiropractic Center, Inc. for the health care services rendered to me. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that I am personally responsible for these services should they not be covered by insurance.

Signature

I have reviewed and agree with this consent form. I also give my permission to this office to use and disclose my health information in accordance with the described Protected Health Information Policies described.

Name of Patient (print)

Signature of Patient (Or Patient Parent/Representative)

Date

Office Representative

Date

Direct Questions to Privacy Official:

Leila McDonald
info@famchiro.com
(512) 347-8033