PATIENT INFORMATION – Please Print

GENERAL INFORMATION

Patient Last Name _____ First Name _____
(Legal Name)
Address _____ Care of _____
(*Parent or Financially responsible person)*
City _____ State _____ Zip _____ Phone (Work) _____
Driver's Lic # _____ No. Children _____ Phone (Home) _____
Out of State Address _____ Phone (Cell) _____
Email Address _____
Spouse's Name _____ Spouse's Daytime Ph# _____

Sex M F	Married Single Widowed Divorced	Date of Birth / /	Social Security Number - -

Patient's Employer's Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Occupation _____

Employed
Full Time Part Time
Retired Not Employed
Student
Full Time Part Time

REFFERED BY:_____

DO YOU HAVE INSURANCE? YES / NO

*****PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARD TO MAKE COPYS*****

PAST CHIROPRACTIC CARE? YES / NO
Clinic/Doctor Name? _____Phone # _____
Address _____
X-rays Taken? **YES / NO**

Are your present problems due to an injury? YES / NO (ONLY COMPLETE IF YOU ANSWERED YES)
_____ On The Job _____Auto Accident _____Personal Injury _____Other _____
Have you reported the Accident? YES / NO To Employer _____ Auto Carrier _____ Other _____
Have you retained an Attorney? YES / NO

In case of Emergency, Notify _____
Relationship _____ Phone Number _____

AUTOMOBILE ACCIDENT/WORKER'S COMPENSATION ONLY

Insurance Company _____ Claim # _____ Policy # _____
Address _____ Phone # _____
City _____ State _____ Zip _____ Adjustor's Name _____
Attorney's Name _____ Contact Name _____
Address _____ Phone # _____

POLICIES

- All first visit charges are payable when services rendered.

- The fee paid for treatment x-rays is for analysis only. **The film itself is the property of this office.**

- We use your email to send you appointment reminders, office updates, monthly newsletter, etc.. **Please Opt Me Out ___ Yes**

_____ (INITIAL) I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand Elite Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Elite Chiropractic will be credited to my account upon receipt. *However,* I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

I *also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.*
I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account.

RELEASE AND ASSIGNMENT

_____ (INITIAL) I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

CONSENT TO EXAMINATION AND DIAGNOSTIC PROCEDURES

_____ (INITIAL) I do hereby authorize the Elite Chiropractic Doctors, Chiropractic Assistants, or Staff to perform upon me examination and diagnostic procedures arising from any current or presently unforeseen conditions, which the Elite Chiropractic Doctors may consider necessary or advisable in the course of my care.

I understand and agree that Elite Chiropractic Doctors have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and conducting of a physical examination are not considered treatment, but is a part of the process of information gathering so that the doctors of Elite Chiropractic can determine whether to accept me as a patient.

CONSENT TO X-RAY

_____ (INITIAL) I do hereby authorize the Elite Chiropractic Doctors to take x-rays of myself (or said minor).

CONSENT TO OPEN DOOR ADJUSTING ENVIRONMENT

_____ (INITIAL) Elite Chiropractic has an open door adjusting area. If you require privacy, it will be provided if your request is in writing. This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is not the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment then other arrangements will be made for you.

(WOMEN ONLY) PREGNANCY RELEASE*

Date of onset of patient's last menstrual period (LMP):_____.

_____ (INITIAL) I do hereby release Elite Chiropractic; it's doctors, and staff from any and all liability. I hereby affirm that I am not pregnant nor am I attempting to get pregnant as of this date and the doctor has my permission to perform a x-ray evaluation. I have been informed adequately of the potential effects of radiation on a developing fetus. If a pregnancy test has been performed, I am also aware that this test is not 100% accurate and may yield false results.

I have read everything provided to me and by signing below I consent to everything that has been explained to me above.

_____ _____

Printed Name of Patient Date Printed Name of Witness

_____ _____

Signature Name of Patient or (Parent or Guardian) Date Signature of Witness

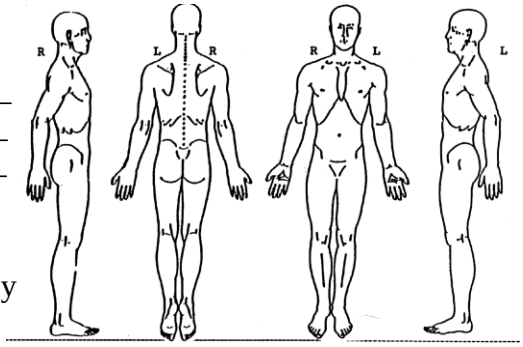
CHIEF COMPLAINT

Patient Name_____ File # _____ Date _____

What is your 1st Major Complaint _____

Site

Please Circle Location of Your Pain



Do you have any other health problems that concern you?
2nd Complaint: 2._____
3rd Complaint: 3._____
4th Complaint: 4._____

Onset

When did complaint start? Date_____ Gradually or Suddenly

Did anything cause or contribute to the onset? **YES / NO**
If yes please explain:_____
_____

Provoking & Palliative (Please place the corresponding number of your complaint next to any provoking or palliative action)

What makes your condition worse? __Nothing __Lifting __Trying to Stand __Standing __Walking __Sitting __Movement __Exercise __Inactivity __Work Activities Other _____

What makes your condition better? __Nothing __Standing __Walking __Sitting __Movement __Exercise __Inactivity __Lying Down __Sleep __Stretching __ Ice __ Heat __ Pain Meds __ OTC's Other _____

Quality (Please place the corresponding number of your complaint next to any sensation you are feeling)

Describe the sensation you feel ____Sharp,____Dull,____Burning,____Throbbing,____Achy,____Sore,____Shooting

Please rate your Pain.
1. 1st Complaint _____ No pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Extreme Pain
2. 2nd Complaint _____ No pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Extreme Pain
3. 3rd Complaint _____ No pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Extreme Pain
4. 4th Complaint _____ No pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Extreme Pain

Radiating

Does your pain radiate to any other part of your body? **YES/NO** Do you experience Numbness/Tingling? **Y/N**
If yes pleases explain:_____

Timing

Is your pain Constant? **YES / NO** Constant since when? _____
Is your pain Intermittent? **YES / NO**
1. 1st Complaint - Frequency_____Times Per Week_____Hrs/Days
2. 2nd Complaint - Frequency_____Times Per Week_____Hrs/Days
3. 3rd Complaint - Frequency_____Times Per Week_____Hrs/Days
4. 4th Complaint - Freguency_____Times Per Week_____Hrs/Days

Have you ever had anything like this before? **YES / NO** If yes when? _____
Has your condition affected your daily activities? **YES / NO** If yes, how?_____
Have you lost work days? **YES / NO** If yes, how many?_____
Has there been any change in your bodily functions (urination, defecation, respiration, digestion, vision, sexual, other)? **YES / NO** If yes, please explain:_____
Name other doctors you have seen for this condition:_____
What are your health goals?_____

PATIENT CASE HISTORY

It is your responsibility to complete these clinic forms accurately and to notify the doctor if any of your information has changed or requires update.*

1. What is your occupation?_____
2. What physical demands does your occupation include? _____
3. What are your hobbies? _____

Please mark if you have had any of these symptoms in the last 12 months

GENERAL SYMPTOMS
___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Allergy (What)
___ Wheezing
___ Neuralgia
___ Numbness or pain in arms/legs/hands

GI
___ Poor Appetite
___ Poor Digestion
___ Excessive Hunger
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids (Piles)
___ Liver Trouble
___ Jaundice
___ Gall Bladder Trouble

EENT
___ Poor Vision
___ Crossed Eyes
___ Pain In Eyes
___ Deafness
___ Earache
___ Ear Discharges
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throats
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Enlarged Thyroid
___ Tonsillitis
___ Sinus Trouble

RESPIRATORY
___ Chronic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing

GENITO-URINARY
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Inability to Control Urine
___ Prostate Trouble

MUSCLE/JOINTS
___ Weakness
___ Twitching
___ Stiff Neck
___ Backache
___ Swollen Joints
___ Tremors
___ Foot Trouble
___ Painful Tailbone
___ Pain B/W Shoulders
___ Hernia
___ Spinal Curvature Or Scoliosis

CARDIOVASCULAR
___ Rapid Heart
___ Slow Heart
___ High Blood Pressure
___ Low Blood Pressure
___ Pain over Heart
___ Previous Heart Trouble
___ Swelling Ankles
___ Poor Circulation
___ Varicose Veins
___ Strokes

SKIN OR ALLERGIES
___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives or Allergy
___ Eczema
___ Allergy to Meds
_____
_____

FOR WOMEN ONLY
___ Painful Periods
___ Excessive Flow
___ Irregular Cycle
___ Hot Flashes
___ Cramps or Backaches
___ Miscarriage
___ Vaginal Discharge
___ Pregnant at this Time
___ Use of oral contraception
What kind and for how long?
_____
_____

OPERATIONS AND PROCEDURES

	DATE		DATE		DATE
Vaccinations		Tubes in ears		Sinus	
Tonsillectomy		Appendectomy		Hernia	
Gall Bladder		Female Organs		Thyroid	
Back Operation		Rectal Surgery		Stomach	

Other _____
Other _____
Hip Replacement R / L_____ Knee Replacement R / L _____ Pacemaker _____
Do you have any other implantable medical devices in your body? YES / NO Explain: _____
Have you had breast implant surgery? YES / NO When? _____

Give the Most current Date: Leave blank if not applicable

Spinal Exam _____
X-ray Exam _____
MRI or CT Exam _____
Lab Exam _____
Last Physical _____
Bone Density _____

FEMALE ONLY
Pap Smear_____
Breast Exam _____

HABITS
Smoking Packs/Day_____
Drinking Alcohol _____
Coffee Cups/Day _____
Soda 12oz's/Day _____

EXERCISE
None _____
Moderate _____
Daily _____

LIFESTYLES & HABITS

1. How many hours of television do you watch a day? ___ < 1 ___ 1-3 ___ 3-5 ___ >5
2. Do you usually snack while watching television? YES / NO
3. How many hours per day do you use a computer at home or work? ___ < 1 ___ 1-3 ___ 3-5 ___ >5
4. How many hours per day do you ride in a car or other vehicle? ___ < 1 ___ 1-3 ___ 3-5 ___ >5
5. How often do you exercise? ___ Daily ___2-5x's/week ___ I Don't Exercise
6. How long do your exercise workouts last? ___ > 1 hour ___ 1 hour ___ 30 min's ___ < 30 min's ___ N/A
7. What are your exercise activities? ___ walking ___ running/treadmill/rowing/climbing ___ swimming _____ stretching ___ yoga/pilates ___ resistance bands ___ group exercise other_____

FAMILY HISTORY OF:

	Diabetes	Heart/Stroke	HBP	Kidney	Cancer	Back	Obesity	Arthritis
Mother	_____	_____	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____	_____	_____
Brother, No of ___	_____	_____	_____	_____	_____	_____	_____	_____
Sister, No of ____	_____	_____	_____	_____	_____	_____	_____	_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ Appendicitis	___ Anemia	___ Heart Disease	___ Arthritis
___ Pneumonia	___ Measles	___ Goiter	___ Epilepsy
___ Rheumatic Fever	___ Mumps	___ Influenza	___ Mental Disorder
___ Polio	___ Chicken Pox	___ Pleurisy	___ Low Back Pain
___ Tuberculosis	___ Diabetes	___ Alcoholism	___ Eczema
___ Whooping Cough	___ Cancer	___ Venereal Infection	___ AIDS
___ Stroke	___ Whiplash	___ Hypertension	___***Osteoporosis***

PLEASE LIST ANY ACCIDENTS, FALLS, OR INJURIES AND DATES

Auto Collisions_____ Treatment Received _____ Date _____
Recreational Vehicle _____ Treatment Received _____ Date _____
Sports _____ Treatment Received _____ Date _____
Job _____ Treatment Received _____ Date _____
Other _____ Treatment Received _____ Date _____

1. List any broken bones (fractures) or dislocations: _____
2. Ever on crutches? YES / NO Why? _____
3. Have you ever had any spinal taps or spinal injections? YES / NO Why? _____
4. Were you ever knocked unconscious? YES / NO How? _____
5. Have you ever had a lapse of memory? YES / NO Why? _____
6. Have you ever had X-Rays, MRI, CT Scan? YES / NO When?_____ By Whom? _____
7. For what ailments were these X-Rays, MRI, CT Scan taken? _____
8. Do you suffer from any other condition other than that for which you are now consulting us? _____
9. Please list any medications you are taking, Prescription or Over-the-Counter: _____
10. Are you currently taking any anti-coagulant (blood thinning) medications (e.g. coumidine, heparin, aspirin, etc)? Y/ N

Elite Chiropractic P.L.L.C.

12233 Ranch Road N. Ste. 107, Austin, TX 78750

TERMS OF ACCEPTANCE/CONCENT TO TREAT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be use to attain it. This will prevent any confusion or disappointment.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Potential Risks: *The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.* While rare, in the practice of chiropractic there are some risk to exam and treatment including, but not limited to: sprains/strains, increased symptoms and pain or no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the same time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I, _____ have read and fully understand the above statements. I have also had the opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek care.

_____ _____

Patient Signature Date

CONSENT TO EVALUATE AND TREAT A MINOR(TREATMENT OF A CHILD UNDER 18 YRS).

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

Parent Signature Date

_____ _____

Witness Signature Date