Family Chiropractic Center, Inc.
Optimal Health Center, LLC
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 and Optimal Health 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,

Your Doctors and Staff

CONFIDENTIAL INFORMATION

We appreciate the opportunity to support you in meeting your desired health outcomes. Please assist us by completing the following information.

Last Name First Name Nick Name

If Child Under 18: Mother's Name Father's Name

Street Address, City, State & Zip

Cell Phone Home Phone Work Phone

Email DOB Age Marital Status M S W D

Occupation Partner's Name:

Names & Ages of Children

Emergency Contact Relationship Phone

Preferred Communication: Text / Email / Phone Health Insurance Co.:

How Did You First Hear About Our Office?: ☐ Friend ☐ Website ☐ Google ☐ Yelp ☐ Other Social Media

Who May We Thank For Referring You To Our Office?

Height: ft in Current Weight: Weight One Year Ago:

How Would You Rate Your Current Overall Health? /10 What Would You Like Your Health To Be? /10

Health Goals: People consult our office with one or more health objectives.

Please indicate the outcomes you desire from your care in our office.

☐ Wellness Care ☐ Get my health back and maintain optimal health

☐ Relief of current symptoms ☐ Minimal activity limitations ☐ No activity limitations

☐ Correction of underlying health problems ☐ Learn exercises or other things I can do to help myself

Signature: _____ Date: _____

YOUR HEALTH HISTORY

Life is a journey. Your health status is a result of many factors and experiences you have had along the way. To best assess how we may help you, we are interested in events and stressors that may have played a part through your formative years as well as current factors.

Pre-Pregnancy

Did your parents…	Yes	No	Unsure
Plan and welcome the pregnancy?	☐	☐	☐
Prepare their bodies for conception and pregnancy?	☐	☐	☐

Pregnancy

Did your mother…	Yes	No	Unsure
Have chiropractic care during pregnancy?	☐	☐	☐
Exercise through pregnancy?	☐	☐	☐
Have a nutritious diet during pregnancy?	☐	☐	☐
Have any significant injury during pregnancy?	☐	☐	☐
Smoke, drink alcohol or take drugs during pregnancy?	☐	☐	☐
Have any significant stress during pregnancy?	☐	☐	☐

Birth Process

Was your birth…	Yes	No	Unsure
Home birth or at birthing center?	☐	☐	☐
Hospital birth?	☐	☐	☐
Early or late according to due date?	☐	☐	☐
Induced labor?	☐	☐	☐
Involving drugs during delivery?	☐	☐	☐
A long or difficult delivery?	☐	☐	☐
Caesarean delivery?	☐	☐	☐

Physical Development	Yes	No	Unsure
Have you experienced…			
Physical abuse by siblings or others?	☐	☐	☐
Being violently pulled by your arm as a child?	☐	☐	☐
Self abuse: head-banging, cutting, etc.?	☐	☐	☐
Get hit or fall on your head?	☐	☐	☐
Have a major fall, as in down stairs?	☐	☐	☐
Auto accident or other trauma?	☐	☐	☐
Sports injuries?	☐	☐	☐

Chemical Exposure	Yes	No	Unsure
Were you breast fed? If so, how long? _____ months	☐	☐	☐
Were you bottle fed? If so, how long? _____ months	☐	☐	☐
Were you vaccinated?	☐	☐	☐
Were you mainly fed nutritious home-cooked meals from fresh ingredients?	☐	☐	☐
Were you mainly fed processed convenience foods and fast foods?	☐	☐	☐
Did you mainly drink filtered or purified water vs tap water?	☐	☐	☐
Did you mainly drink sodas or sugary tea, etc.?	☐	☐	☐

Mental / Emotional Stress	Yes	No	Unsure
Was there communication breakdown in your childhood home?	☐	☐	☐
Was there the loss of a parent or close relative	☐	☐	☐
Was there ongoing stress in your family?	☐	☐	☐

Please provide details of above or other stresses you experienced.

_____

Family Medical: Please note any significant family medical history. _____

_____

_____

Have you experienced a loss in the last 5 years? (e.g. relationship, family, business, financial) Y N (If yes, please describe)

_____

Any significant current stresses? ☐ Home ☐ Work ☐ Family ☐ Financial _____

_____

Food Allergies: ☐ Gluten ☐ Dairy ☐ Other: _____

Lifestyle	Yes	No	Unsure
Do you smoke?	☐	☐	☐
Do you drink alcohol?	☐	☐	☐
Do you stay well hydrated?	☐	☐	☐
Do you mainly eat nutritious home-cooked meals from fresh ingredients?	☐	☐	☐
Do you exercise regularly?	☐	☐	☐
Do you sleep well?	☐	☐	☐
Are your teeth healthy?	☐	☐	☐
Are you mentally stressed?	☐	☐	☐
Is 'screen time' a major part of your day?	☐	☐	☐
Do you frequently sit for hours at a time? How many hours sitting a day? _____	☐	☐	☐

Do you crave sweets and regularly eat candy or sugary foods? Y N Do you use artificial sweeteners? Y N

Current Sports: _____

Injuries: _____

Surgeries: _____

Current Medications: _____

Supplements: _____

Do You Use: ☐ Orthotics ☐ Shoe Lift ☐ Back Brace ☐ Other Support _____

Reason For Seeking Care Now: ☐ Wellness Care (Skip to the Next Page)

☐ Treatment of Health Concerns (Provide Details)

Primary Concern: _____ Severity: ____/10 % of Time Noticed ____%

Began: _____ Event: _____

Sensation: ☐ Sharp ☐ Burning ☐ Dull ☐ Ache ☐ Sore ☐ Stiff ☐ Spasm ☐ Numb ☐ Radiates to _____

Progression: ☐ Getting Worse ☐ Getting Better ☐ Not Changing ☐ Previous Episodes? Y N _____

Worse When You: ☐ Sit ☐ Stand ☐ Walk ☐ Lift ☐ Exercise ☐ Drive _____

Improves With: ☐ Rest ☐ Lying Down ☐ Massage ☐ Cold ☐ Heat ☐ Meds _____

Recent Medical Care or Other Treatment: _____

_____

_____

Previous Chiropractic Care Y / N Last Visit: _____

What type of care did they provide?

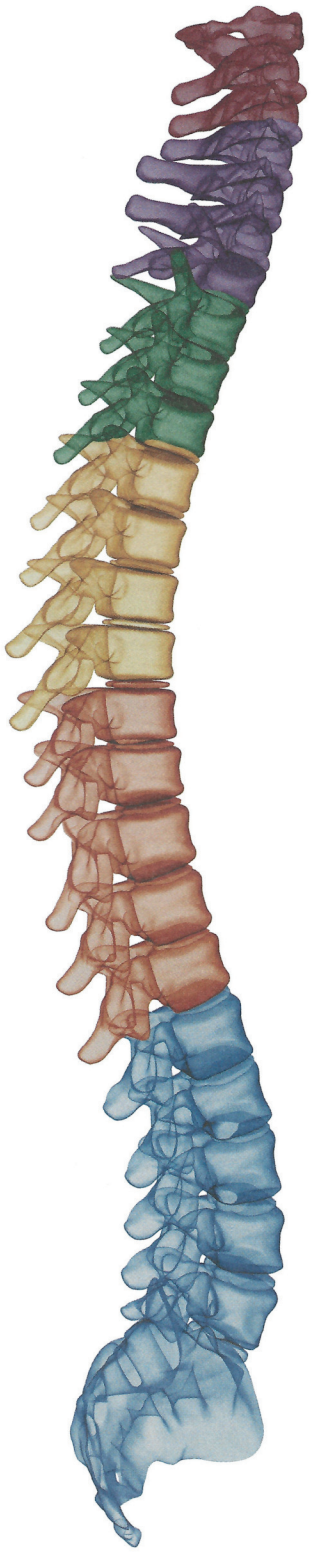
☐ 'Limited Scope' Chiropractor (Focuses mainly on neck and back pain)

☐ 'Optimal Health' Chiropractor (Focuses on optimal health & underlying causes of pain and health concerns)

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Chron's, Colitis, IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: ___/___/___

Family Chiropractic Center, Inc. / Optimal Health Center, LLC
Acknowledgement for Use and Disclosure of Protected Health Information and Consents to Evaluation, Treatment and Financial Policies

Notice of Privacy Practices I have read and understand the Family Chiropractic Center, Inc. / Optimal Health Center, LLC Notice of Privacy Practices; ***"Your Information. Your Rights. Our Responsibilities"*** as well as "Informed Consents" which describe how my Protected Health Information (PHI) may be used or disclosed. I understand that I may request a copy of the Notice at the Front Desk or view it at our website, 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 / OHC 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 insurance companies will not cover a portion of the services or supplies I receive at this office for reimbursement. I will be informed in advance of these items. They will not be billed to my insurance company and will be my sole financial responsibility. The following is a partial list of these services and their standard fees at the time of this notice:

Insight Neuro-diagnostic Scan Suite	$ 55
Neuro-Muscular Reflex Examination	$ 45
Muscle Priority Assessment	$ 25
Optimal Health / Wellness Visit	$ 80
Nutritional Supplements / Supplies	Varies

Informed Consent of Appointment Scheduling Policies If I discover that I am not able to make a scheduled appointment, I will notify this office at the earliest possible opportunity. **I understand that if I miss an appointment or fail to provide twenty-four hours notice prior to cancelling 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.

_____ _____ _____
Name of Patient (print) **Signature of Patient (Or Patient Parent/Representative)** **Date**

_____ _____
Office Representative **Date**

Direct Questions to Privacy Official:
Dr. Mark Sanders
info@famchiro.com
(512) 347-8033

Revised March 7, 2024