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 (Cell) _______________________
Cell Phone Carrier for Text Reminders: **(AT&T,Verizon,T-Mobile,Cricket…)** _______________________________
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

HOW DID YOU FIND US? _____________________________

DO YOU HAVE INSURANCE? YES / NO INSURANCE COMPANY _________________________

*****PLEASE GIVE THE FRONT DESK YOUR INSURANCE & D.L. 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

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.

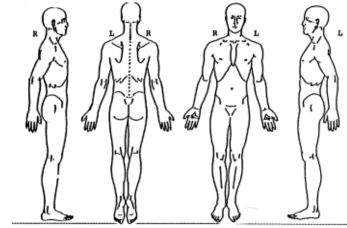
I have read everything provided to me and by signing below I consent to everything that has been explained to me above.

______________________________________ ______________________ ______________________________________
Printed Name of Patient Date Printed Name of Witness

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

CHIEF COMPLAINT

Please Circle Location of Your Pain



What is your 1st Major Complaint ____
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?____

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 __________

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

___ Appendicitis ___ Anemia ___ Heart Disease
___ Pneumonia ___ Goiter ___ Epilepsy
___ Rheumatic Fever ___ Influenza ___ Mental Disorder
___ Polio ___ Pleurisy ___ Low Back Pain
___ Tuberculosis ___ Diabetes ___ Alcoholism
___ Whooping Cough ___ Cancer ___ AIDS
___ Stroke ___ Whiplash ___ Hypertension
___ Osteoporosis

Office Use Only:

ICD: ____

CPT: ____

Elite Chiropractic P.L.L.C.

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

TERMS OF ACCEPTANCE/CONSENT 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