

# 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 Widowed	Single 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

**REFERRED 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.

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**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 1<sup>st</sup> Major Complaint \_\_\_\_\_

## Site

Do you have any other health problems that concern you?

2<sup>nd</sup> Complaint: 2. \_\_\_\_\_

3<sup>rd</sup> Complaint: 3. \_\_\_\_\_

4<sup>th</sup> 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 please 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 - Frequency _____	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? \_\_\_\_\_

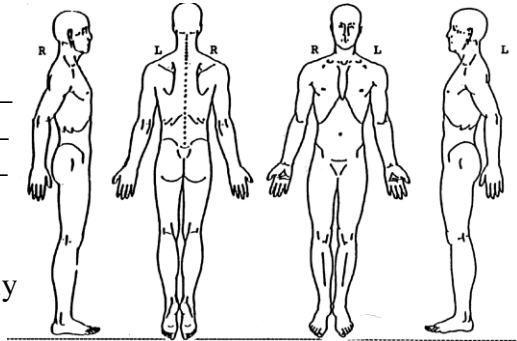
Have you lost work days? **YES / NO** If yes, how many? \_\_\_\_\_

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? \_\_\_\_\_

## Please Circle Location of Your Pain



# 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			
<b>GENERAL SYMPTOMS</b>	<b>GI</b>	<b>EENT</b>	<b>RESPIRATORY</b>
<input type="checkbox"/> Headache	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Poor Vision	<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Fever	<input type="checkbox"/> Poor Digestion	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Spitting Blood
<input type="checkbox"/> Chills	<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Pain In Eyes	<input type="checkbox"/> Spitting Phlegm
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Belching or Gas	<input type="checkbox"/> Deafness	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Fainting	<input type="checkbox"/> Nausea	<input type="checkbox"/> Earache	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Ear Discharges	
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Nasal Obstruction	<b>GENITO-URINARY</b>
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Pain over Stomach	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Allergy (What)	<input type="checkbox"/> Hemorrhoids (Piles)	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Inability to Control Urine
<input type="checkbox"/> Neuralgia	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Enlarged Thyroid	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Numbness or pain in arms/legs/hands	<input type="checkbox"/> Gall Bladder Trouble	<input type="checkbox"/> Tonsillitis	
<input type="checkbox"/> Sinus Trouble		<input type="checkbox"/> Sinus Trouble	<b>FOR WOMEN ONLY</b>
<b>MUSCLE/JOINTS</b>	<b>CARDIOVASCULAR</b>	<b>SKIN OR ALLERGIES</b>	<input type="checkbox"/> Painful Periods
<input type="checkbox"/> Weakness	<input type="checkbox"/> Rapid Heart	<input type="checkbox"/> Skin Eruptions	<input type="checkbox"/> Excessive Flow
<input type="checkbox"/> Twitching	<input type="checkbox"/> Slow Heart	<input type="checkbox"/> Itching	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Stiff Neck	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bruising Easily	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Backache	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Dryness	<input type="checkbox"/> Cramps or Backaches
<input type="checkbox"/> Swollen Joints	<input type="checkbox"/> Pain over Heart	<input type="checkbox"/> Boils	<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Tremors	<input type="checkbox"/> Previous Heart Trouble	<input type="checkbox"/> Sensitive Skin	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Foot Trouble	<input type="checkbox"/> Swelling Ankles	<input type="checkbox"/> Hives or Allergy	<input type="checkbox"/> Pregnant at this Time
<input type="checkbox"/> Painful Tailbone	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Eczema	<input type="checkbox"/> Use of oral contraception
<input type="checkbox"/> Pain B/W Shoulders	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Allergy to Meds	What kind and for how long? _____ _____
<input type="checkbox"/> Hernia	<input type="checkbox"/> Strokes	_____	
<input type="checkbox"/> Spinal Curvature Or Scoliosis		_____	

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 \_\_\_\_\_ **FEMALE ONLY**  
 X-ray Exam \_\_\_\_\_ Pap Smear \_\_\_\_\_  
 MRI or CT Exam \_\_\_\_\_ Breast Exam \_\_\_\_\_  
 Lab Exam \_\_\_\_\_  
 Last Physical \_\_\_\_\_  
 Bone Density \_\_\_\_\_

**HABITS**

Smoking Packs/Day \_\_\_\_\_  
 Drinking Alcohol \_\_\_\_\_  
 Coffee Cups/Day \_\_\_\_\_  
 Soda 12oz's/Day \_\_\_\_\_

**EXERCISE**

None \_\_\_\_\_  
 Moderate \_\_\_\_\_  
 Daily \_\_\_\_\_

**LIFESTYLES & HABITS**

- How many hours of television do you watch a day? \_\_\_ < 1 \_\_\_ 1-3 \_\_\_ 3-5 \_\_\_ >5
- Do you usually snack while watching television? YES / NO
- How many hours per day do you use a computer at home or work? \_\_\_ < 1 \_\_\_ 1-3 \_\_\_ 3-5 \_\_\_ >5
- How many hours per day do you ride in a car or other vehicle? \_\_\_ < 1 \_\_\_ 1-3 \_\_\_ 3-5 \_\_\_ >5
- How often do you exercise? \_\_\_ Daily \_\_\_ 2-5x's/week \_\_\_ I Don't Exercise
- How long do your exercise workouts last? \_\_\_ > 1 hour \_\_\_ 1 hour \_\_\_ 30 min's \_\_\_ < 30 min's \_\_\_ N/A
- 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       | ___ <i>Osteoporosis</i> |

**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 _____

- List any broken bones (fractures) or dislocations: \_\_\_\_\_
- Ever on crutches? YES / NO Why? \_\_\_\_\_
- Have you ever had any spinal taps or spinal injections? YES / NO Why? \_\_\_\_\_
- Were you ever knocked unconscious? YES / NO How? \_\_\_\_\_
- Have you ever had a lapse of memory? YES / NO Why? \_\_\_\_\_
- Have you ever had X-Rays, MRI, CT Scan? YES / NO When? \_\_\_\_\_ By Whom? \_\_\_\_\_
- For what ailments were these X-Rays, MRI, CT Scan taken? \_\_\_\_\_
- Do you suffer from any other condition other than that for which you are now consulting us? \_\_\_\_\_
- Please list any medications you are taking, Prescription or Over-the-Counter: \_\_\_\_\_
- 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