West End Chiropractic

Thank you for wanting to make West End Chiropractic your health care provider. Like any medical clinic, we value your confidence and want to protect your privacy. Before you come in for your first appointment, please fill out the following forms and then bring them with you. If you have any questions, please call our office at 512-472-1116.

Thank you,
Dr. Craig E. Richardson

Patient Introduction Card

No: ____________________ (for office use only) Date: ____________

Name (Mr. Mrs. Miss Ms.): ____

Address: ____

City/State/ZIP ____

Phone (H): ____________ Phone (C): ____________ Email: ____________________

Married:____ Single:____ Other:____________ Age: ______ Date of Birth: ____________

Children? Yes / No Names and Ages: ____________________________________

Occupation: ____________________ Employer: ____________________

Office Address: ______________________________ Office Phone: ____________

Previous Chiropractic Care? Yes / No Doctor's Name: ____________________

Name of Insurance Company: ____________________________________

Emergency Contact: ____________________________________

Contact Phone/Cell Number: ____________________________________

Social Security Number: ____________________________________

Who (or what source) referred you?____________________________________

Major Complaint: ____________________________________

It is usual and customary to pay for services as rendered unless otherwise arranged.

West End Chiropractic

Name: ______________________ Confidential Patient Health Record

Current Health Condition

What is your chief health concern? ______________________

If you have symptoms, list them: ______________________

When did this condition begin? Initially: ____________ Most Recently: ____________

How often do you experience symptoms? ______________________

What makes it feel better? (Hot bath, stretching, etc.) ______________________

What makes it feel worse? (Movement, sitting, etc.) ______________________

How do these symptoms impact your life? (Can't work out, can't do housework or yardwork, etc.)

____

Rate the symptoms: 0 1 2 3 4 5 6 7 8 9 10

(Least pain) (Worst)

What kind of symptoms do you have? (Circle all that apply)

Sharp Pinching Dull Ache Burning Tingling Throbbing Radiating

Do the symptoms go into your arms, legs, or head? ______________________

When does it hurt the most? ____________ The least? ____________

Describe how it feels as the day goes on: ______________________

Other doctors seen for this condition: Yes / No Who: ______________________

Past Medical History

What medications are you currently taking? ______________________

Do you have any medically-diagnosed conditions? ______________________

Have you had any prior hospitalizations? ______________________

Have you had any surgeries? ______________________

Have you been involved in any motor vehicle accidents? ______________________

Have you had any major falls or broken bones? ______________________

Health Questionnaire

Please check each of the conditions below that you have experienced in the last 6 months

Date: ______________

Patient: ____ No: ______________

Musculoskeletal System

- ☐ Low back pain
- ☐ Mid back pain
- ☐ Pain between shoulder
- ☐ Neck pain
- ☐ Arm problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Spasms
- ☐ Broken bones
- ☐ Shoulder pain

Genito-urinary System

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored Urine

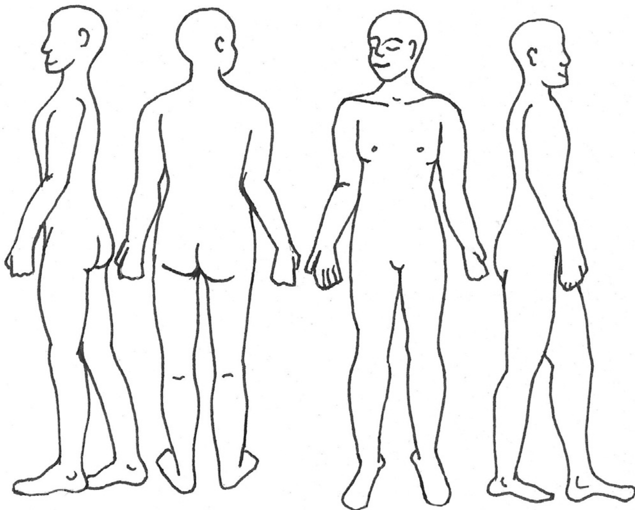
Female

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

ARE YOU PREGNANT?

☐ **YES** ☐ **NO**

Symptom Localization



P ____ Pain N ____ Numb S ___ Spasm

T ___ Tender H ___ Hypothesia (Reduced Feeling)

Pain Index: Least 1 2 3 4 5 6 7 8 9 10 Worst

Gastrointestinal System

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gallbladder problems
- ☐ Weight trouble

Nervous System

- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscles jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Habits

- ☐ Cigarettes
- ☐ Alcohol abuse
- ☐ Coffee or tea
- ☐ Drug abuse
- ☐ ____________________

Cardiovascular and Respiratory Systems

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

Eye, Ear, Nose and Throat

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficulty breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty speaking
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

Patient Signature: ____________________________

DO NOT WRITE BELOW THIS LINE

West End Chiropractic

1619 West 6th Street, Austin, TX 78703
(512) 472-1116, FAX (512) 472-1171

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, ________________________________(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

I, ________________________________(print) acknowledge that I have reviewed the above information and DO NOT give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient Signature: ____ Date: _______________

ASSIGNMENT OF BENEFITS

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

Patient Signature: ____ Date: _______________

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

Patient Signature: ____ Date: _______________