

# Welcome To Chiropractic Arts Center of Austin, P.C.

## Practice Member Information and Acceptance

Whom may we thank for your referral? \_\_\_\_\_

Name _____	Male / Female _____	Today's Date _____
Address _____	City _____	State _____ Zip _____
Home # _____	Cell # _____	Work# _____ Ext. _____
Date of Birth _____	Age _____	Race _____ Social Security # _____
Single / Married / Divorced / Separated / Widowed _____	Drivers License # _____	Medicare? Y / N _____
Employer _____	Occupation _____	
Address _____	City _____	State _____ Zip _____
Spouse's Name _____	Phone # in Case of Emergency _____	
Children's Names and Ages _____		
Has your family been under chiropractic care? Y / N _____	When? _____	

**Please check any of the following you may have:**

- |   |  |
|---|--|
| <input type="checkbox"/> Headaches / Migraines                        | <input type="checkbox"/> High Cholesterol                |
| <input type="checkbox"/> Memory Loss                                  | <input type="checkbox"/> Digestive Disorders             |
| <input type="checkbox"/> Vertigo / Dizziness                          | <input type="checkbox"/> Constipation / Diarrhea         |
| <input type="checkbox"/> Irritability                                 | <input type="checkbox"/> Decreased Sexual Function       |
| <input type="checkbox"/> Eyes Burning                                 | <input type="checkbox"/> Loss of Bowel / Bladder Control |
| <input type="checkbox"/> Ear Ringing                                  | <input type="checkbox"/> Sleep Difficulty                |
| <input type="checkbox"/> Allergies                                    | <input type="checkbox"/> Impaired Balance                |
| <input type="checkbox"/> Sinus Problems                               | <input type="checkbox"/> Stress                          |
| <input type="checkbox"/> Jaw Problems / TMJ                           | <input type="checkbox"/> Tension                         |
| <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> PMS / Female Problems           |
| <input type="checkbox"/> Shortness of Breath / Breathing Difficulties | <input type="checkbox"/> Arthritis / Joint Pain          |
| <input type="checkbox"/> Reflux / Heartburn                           | <input type="checkbox"/> Arm / Shoulder Pain             |
| <input type="checkbox"/> Chest Pain                                   | <input type="checkbox"/> Back Pain / Stiffness           |
| <input type="checkbox"/> Fatigue                                      | <input type="checkbox"/> Tingling / Numbness-            |
| <input type="checkbox"/> High Blood Pressure                          | List Area: _____   |

Comments / Concerns:

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**Please Complete the Following Information:**

Previous Chiropractor: \_\_\_\_\_ Have you had spinal x-rays in the last 3 years? Y / N \_\_\_\_\_

Is this current condition related to: (circle) Auto Accident / Work Injury Date of Injury \_\_\_\_\_

Other doctors consulted for this condition: \_\_\_\_\_ Results: \_\_\_\_\_

Does this condition interfere with your? (circle) Work Sleep Daily Routine Recreation

Have you been treated for any other health conditions in the last year? Y / N \_\_\_\_\_

If so, what? \_\_\_\_\_

List any previous surgery(s): \_\_\_\_\_

List any medications including homeopathic: \_\_\_\_\_

Do you exercise regularly? Y / N What do you do? \_\_\_\_\_ How often? \_\_\_\_\_

Do you sleep on your: Back Side Stomach How many hours per day do you sit? \_\_\_\_\_

**\*Women Only: Is there any chance that you could be pregnant? \_\_\_\_\_**  
**When was the 1<sup>st</sup> day of your last period? \_\_\_\_\_**

### Terms of Acceptance

When an individual seeks chiropractic health care and we accept this individual for such care, it is essential for both to be working toward the same objective. It is important that you understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

**Chiropractic has only one goal: To eliminate subluxations within the spinal column, which interfere with the expression of the body's innate wisdom.**

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic methods of correction are gentle, specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column, which causes the 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.

We do not offer to diagnose or treat any diseases or conditions other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you of our findings. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

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 body's innate wisdom, by specific chiropractic adjustments to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print Name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between the carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand if I suspend or terminate my care at this office, any outstanding fees for professional services will be immediately due and payable. I hereby authorize the doctors at Chiropractic Arts Center of Austin, P.C. and whomever they may designate as their assistants to administer any care, as they deem necessary. I also understand that all individuals have a right to achieve optimal health and no individual will be discriminated against because of race, color, creed, religion, sex, age, sexual preference, national origin, citizenship, marital status, disability, veteran status or any other status or characteristic protected under federal, state, or local laws.

I certify that the above information is true and correct to the best of my knowledge.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_