

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

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

Legal Name _____	Male / Female _____	Today's Date _____
Address _____	City _____	State _____ Zip _____
Home # _____	Cell # _____	Work# _____ Ext. _____
Date of Birth _____	Age _____	Single / Married / Divorced / Separated / Widowed _____ Race _____
Employer _____	Occupation _____	
Address _____	City _____	State _____ Zip _____
Emergency Contact Name & Phone #: _____		
Are you and your family under chiropractic care? Y / N Chiropractor/When? _____		

**Area of Concern:** \_\_\_\_\_ **When Did it Start?** \_\_\_\_\_

**What makes it worse?** \_\_\_\_\_ **What makes it better?** \_\_\_\_\_

**Circle:** Achy    Stiff    Sharp    Burning    Stabbing    Pins & Needles    Numbness

**Pain scale: (0 = None, 10 = Worst)** \_\_\_\_\_

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

**Other Doctors consulted for this condition:** \_\_\_\_\_

**Results:** \_\_\_\_\_

**Have you been treated for any other health conditions in the last year? Y / N If so, what?** \_\_\_\_\_

**Previous Surgery(s):** \_\_\_\_\_

**Medications (Including over the counter or homeopathic):** \_\_\_\_\_

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

**Please check any of the following you have or have had in the past:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> General Stiffness     | <input type="checkbox"/> Sleep Apnea / Difficulty Sleeping      | <input type="checkbox"/> Diabetes                               |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Carpal Tunnel / Hand Problems          | <input type="checkbox"/> Decreased Sexual Function              |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Elbow Problems                         | <input type="checkbox"/> PMS / Female Problems                  |
| <input type="checkbox"/> Irritability          | <input type="checkbox"/> Arm / Shoulder Pain                    | <input type="checkbox"/> Infertility                            |
| <input type="checkbox"/> Stress                | <input type="checkbox"/> Mid - Back Pain                        | <input type="checkbox"/> Loss of Bowel / Bladder Control        |
| <input type="checkbox"/> Tension               | <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Knee Pain                              |
| <input type="checkbox"/> Neck Pain             | <input type="checkbox"/> Breathing Difficulties                 | <input type="checkbox"/> Foot Pain                              |
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Lung Disease                           | <input type="checkbox"/> Immune Disorder - List: _____          |
| <input type="checkbox"/> Vertigo / Dizziness   | <input type="checkbox"/> Reflux / Heartburn                     | <input type="checkbox"/> Arthritis / Joint Pain – Area: _____   |
| <input type="checkbox"/> Memory Loss           | <input type="checkbox"/> Chest Pain                             | <input type="checkbox"/> Fractures - List: _____                |
| <input type="checkbox"/> Impaired Balance      | <input type="checkbox"/> High Blood Pressure                    | <input type="checkbox"/> History / Current Cancer - List: _____ |
| <input type="checkbox"/> Seizure Disorders     | <input type="checkbox"/> Previous Heart Attack                  | <input type="checkbox"/> Pain / Stiffness Area: _____           |
| <input type="checkbox"/> Eyes Burning          | <input type="checkbox"/> Heart Surgery / Pacemaker              | <input type="checkbox"/> Tingling / Numbness - Area: _____      |
| <input type="checkbox"/> Ear Ringing           | <input type="checkbox"/> Heart Murmur / Congenital Heart Defect |   |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Low Back Pain                          |   |
| <input type="checkbox"/> Sinus Problems        | <input type="checkbox"/> Digestive Disorders                    |   |
| <input type="checkbox"/> Jaw Problems / TMJ    | <input type="checkbox"/> Constipation / Diarrhea                |   |
| <input type="checkbox"/> Thyroid Problems      | <input type="checkbox"/> Ulcers / Colitis                       |   |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Kidney Problems                        |   |

**Women Only:** Is there any chance you could be pregnant? Y / N First Day of Your Last Period? \_\_\_\_\_

**Is there anything else we should know about you or your health?** \_\_\_\_\_

## Terms of Acceptance

When an individual seeks health care in our office 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.

**Cold Laser:** Cold Laser works by delivering light energy units, in the form of photons, to damaged cells. Similar to photosynthesis in plants, cold laser creates a biochemical increase in cell energy used to help transform live cells from a state of illness to stable and healthy.

**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. I also have read and fully understand the above statements.

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

Signature \_\_\_\_\_