Today's Date: _____

AUSTIN LIFE CHIROPRACTIC

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Mobile Phone: _____ Mobile Carrier: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Names and ages of children: _____

Name & Number of Emergency Contact: _____ _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: **Primary**: _____

Second: _____ Third: _____ Fourth: _____

On a scale of **1-10** with **10** being the worst pain and **zero** being no pain, rate your complaints by ***circling the number***:

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ Constant **OR** ☐ Off and on during the day **OR** ☐ Comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

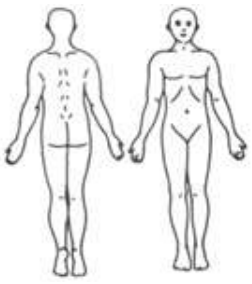
How long were you under care: _____ What were the results? _____

PREVIOUS CHIROPRACTOR:

Name: _____ Clinic: _____ Phone: _____

MEDICAL DOCTOR:

Name: _____ Clinic: _____ Phone: _____



PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

RESTRICTED ACTIVITIES: _____ _____

Continued on next page . . .

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:_____

_____

PAST HISTORY

Have you suffered with a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times? _____
When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____
Who provided it: _____ **How long ago?** _____
What were the results: ☐ Favorable ☐ Unfavorable→ please explain: _____

_____

Please identify any types of activities/jobs you have done in the past that have imposed any physical stress on your body:

_____

Have you ever been diagnosed with any of the following conditions? Please indicate with a **P=*Past*, C=*Currently*, N=*Never***

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteoarthritis ___ Diabetes ___Cerebral Vascular ___ Other : _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Son(s) ☐ Daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

Other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to Austin Life Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Austin Life Chiropractic for any and all services I receive at this office.

_____ _____/_____/_____
Patient or Authorized Person's Signature **Date Completed**

_____ _____/_____/_____
Doctor's Signature **Date Form Reviewed**

REVIEW OF SYMPTOMS: Please mark P=*Past*, C=*Current*

Neurological
___ Allergies
___ Anxiety
___ Depression
___ Dizziness
___ Nervousness
___ Numbness
___ Loss of Sleep
___ Pins & Needles
___ Tingling Arms/Hands
___ Tingling Legs/Feet

Digestive
___ Excessive gas
___ Colon Problems/IBS
___ Constipation
___ Diarrhea
___ Hemorrhoids
___ Gall Bladder trouble
___ Liver trouble
___ Anorexia/Bulimia
___ Ulcers
___ Acid Reflux/Heartburn

Head, Eyes, Ears, Nose & Throat
___ Migraines
___ Headaches
___ Ear Infection
___ Eye Infection
___ Glaucoma
___ Sore throat
___ Thyroid problems
___ Sinus Infection
___ Tonsillitis
___ Ringing in Ears
___ Hearing Loss

Muscle & Joint
___ Low Back Pain
___ Mid Back Pain
___ Scoliosis
___ Arthritis
___ Bursitis
___ Poor Posture
___ Neck Pain
___ Jaw Pain/TMJ
___ Shoulder Pain
___ Hip disorders
___ Knee Pain
___ Ankle/Foot Pain

Cardiovascular
___ High Blood Pressure
___ Low Blood Pressure
___ Heart Disease
___ Rapid Heartbeat
___ Abnormal Heartbeat
___ High Cholesterol
___ Pain over Heart
___ Poor Circulation
___ Excessive Bruising
___ Swelling of Ankles
___ Varicose Veins

Respiratory
___ Asthma
___ Apnea
___ Difficulty Breathing
___ Emphysema
___ Chronic Cough
___ Difficulty Sleeping

Genitourinary
___ Bedwetting
___ Infertility
___ Kidney Infection
___ Erectile Dysfunction
___ Sexual Dysfunction
___ Prostate Issues

Skin
___ Acne
___ Dryness
___ Eczema
___ Rash
___ Yeast/fungus

Constitutional
___ Fainting
___ Fatigue
___ Low Libido
___ Poor Appetite
___ Weakness

Female
___ Heavy Flow
___ PMS
___ Irregular Cycle
___ Painful Cycle
___ Discharge
___ Menopausal Yes No

Other:
___ ADHD
___ Mood Changes
___ Diabetes
___ Autism
___ Learning Disability
___ AIDS
___ Gout
___ Hepatitis
___ Anemia
___ Alcoholism
___ Epilepsy
___ Cancer
___ Glaucoma
___ Fibromyalgia
___ Herniated Disc
___ Arnold Chiari
___ Multiple Sclerosis
___ Rheumatoid Arthritis
___ Spinal Degeneration
___ Herniated Disc
___ Other: _____

YOUR GOALS FOR CARE:

❑ Feel better quickly – Pain relief
❑ Feel better and prevent return of problems
❑ Have a healthier spine
❑ I want optimum health and to live a healthier lifestyle

Continued on next page . . .

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Whom may we thank for referring you to our office? _____

Patient's Signature: _____ **Today's Date:** ___/___/___