

Please Read the Following Statements Carefully and Sign After Each Statement to Indicate Your Understanding and Acceptance of Our Office Policies.

**AUTO PIP:**

We will accept assignment on all Auto Insurance PIP plans, EXCEPT *ALLSTATE*. We file the necessary paperwork and are paid directly by your PIP Insurance carrier. Please provide all policy information for us to file your claim (i.e. your insurance company contact information, claim number, etc...).

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18 Years Old)    Relationship to Patient    Today's Date

**HEALTH INSURANCE:**

This office is not under contract with any health insurance plans, therefore, we are not able to file your claim or be paid directly by your insurance company. We are considered an "out-of-network" provider on all/most PPO plans, therefore your insurance company should reimburse you for your treatment up to the allowable percentage after your deductible. You will be responsible for paying your bill in full as services are rendered, and you will be provided an itemized receipt sufficient for your insurance purposes. HMO Plans require that you go to doctors on their list, therefore you will not be reimbursed for your visit here. We Accept VISA, MASTERCARD, and DISCOVER CARD for your convenience.

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18 Years Old)    Relationship to Patient    Today's Date

**MEDICARE:**

While we do not accept assignment on Medicare and cannot be paid directly by Medicare, we will file your claim to Medicare as a courtesy to you. Medicare should reimburse you for your treatment up to the allowable percentage after your deductible. You will be responsible for paying your bill in full as services are rendered. Please provide us with your Medicare card so we can make a copy of it.

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18 Years Old)    Relationship to Patient    Today's Date

**WORKER'S COMP:**

We are no longer a worker's compensation provider under the State of Texas and therefore we are unable to treat any work related injuries until you are released from said worker's comp claim.

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18 Years Old)    Relationship to Patient    Today's Date

**CANCELLATION POLICY:**

In order to avoid a \$45 Missed Appointment Fee, we require a **2 Hour Notice** if you need to cancel your appointment.

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18 Years Old)    Relationship to Patient    Today's Date

**TREATMENT ROOM POLICIES:**

Only the patient is allowed in the room with the doctor, with the exception of small children or extenuating circumstances requiring the presence of another person. We make those determinations on a case-by-case basis.

In order to better know you and your family, we welcome your child(ren) in our office. However, we find that the nature of our hydraulic equipment poses a safety hazard. Therefore, we ask that you bring someone with you to watch your child(ren) in the waiting area while you are receiving your treatment.

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18 Years Old)    Relationship to Patient    Today's Date

**Please Fill Out This Form Completely and Legibly. Leave Nothing Blank.  
If Something Does Not Apply, Write "N/A" on the Line.**

**Personal Contact Information**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex (Circle One): M F  
Work Phone \_\_\_\_\_ Employer \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
Marital Status (Circle One): Single Partnered Married Divorced Widowed Number of Children \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

**Medical History**

Do **You** Have Any History Of (Check All That Apply):

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Dementia      | <input type="checkbox"/> Alzheimer's     | <input type="checkbox"/> Parkinson's        | <input type="checkbox"/> Concussion    |
| <input type="checkbox"/> Head Injury   | <input type="checkbox"/> Depression      | <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Other _____   |

Elaborate on Any **Family** History of the Above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have You Ever Had Any Broken Bones? Yes No

Which Bone(s) and When? \_\_\_\_\_

Any Long Term Effects? \_\_\_\_\_

Have You Ever Had Any Surgeries? Yes No

Please List Any Surgical Procedures and Their Respective Dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When Was Your Last Physical Exam? \_\_\_\_\_

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

Results of Latest Lab Work: \_\_\_\_\_

**Nutrition and Exercise History**

Do You Smoke? Yes No

Have You Ever Smoked? Yes No If Yes, Cessation Date \_\_\_\_\_

Do You Drink Alcohol? Yes No If Yes, How Much and How Often? \_\_\_\_\_

Are You a Vegetarian? Yes No If Yes, What Kind? \_\_\_\_\_

How Many Meals Do You Eat Per Day? \_\_\_\_\_ How Often Do You Eat Out? \_\_\_\_\_

What Type of Food Do You Eat When You Eat Out? \_\_\_\_\_

Do You Exercise Regularly? Yes No If Yes, What Kind of Exercise and How Often? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List All Medications, Vitamins, and Supplements That You Are Currently Taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Fill Out This Form Completely and Legibly. Leave Nothing Blank.  
 If Something Does Not Apply, Write "N/A" on the Line.

**History of Present Illness**

Describe the Symptoms that You are Experiencing, Their Location(s), and Types of Pain: \_\_\_\_\_

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When Did You First Notice These Symptoms? \_\_\_\_\_

Has This Happened Before (Circle One)? Yes No If Yes, When? \_\_\_\_\_

**Mark the Areas Where You Feel The Described Sensations on the Pictures Below.**  
**Mark Areas of Radiation.**  
**Include All Affected Areas.**

Numbness

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Pins & Needles

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Burning

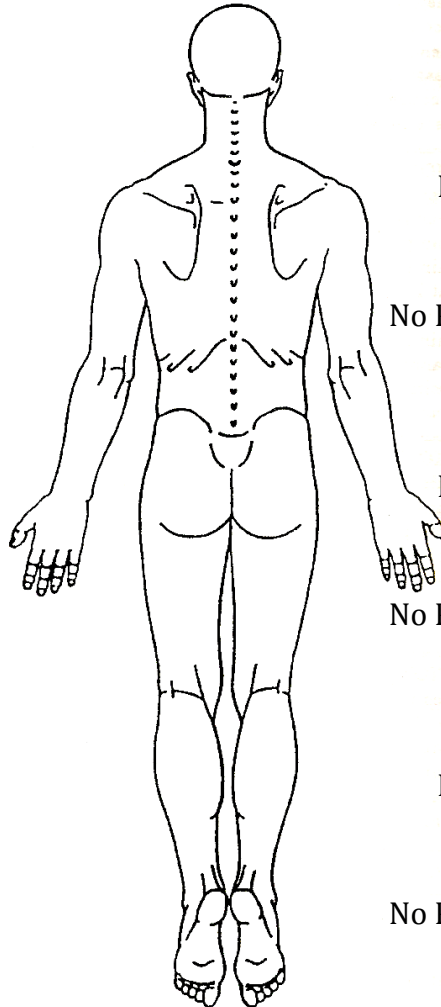
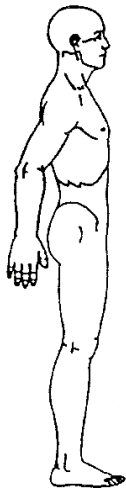
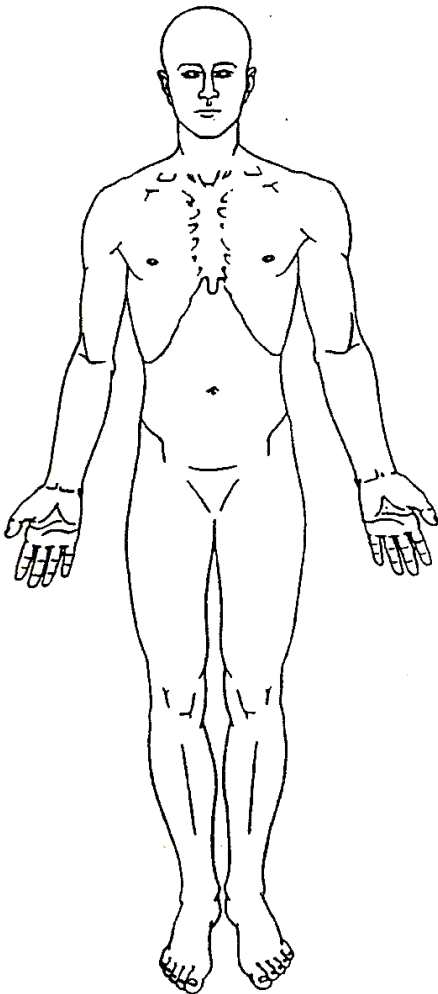
XXXXX

Aching

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Stabbing

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**Neck - Shoulder - Arm Pain**  
 On A Scale of Zero to Ten,  
 I Rate My Discomfort as Follows:



**Mid Back Pain**  
 On A Scale of Zero to Ten,  
 I Rate My Discomfort as Follows:



**Low Back and Leg Pain**  
 On A Scale of Zero to Ten,  
 I Rate My Discomfort as Follows:



**Please Fill Out This Form Completely and Legibly. Leave Nothing Blank.  
If Something Does Not Apply, Write "N/A" on the Line.**

Was the Pain Caused By (Check All That Apply):

- Strain, Date of Strain \_\_\_\_\_
- Fall, Date of Fall \_\_\_\_\_
- Mental Stress
- Emotional Stress
- Auto Accident, Date of Accident \_\_\_\_\_

Is This A Work Related Accident (Circle One)?    Yes    No

**We Are Not A Worker's Compensation Provider Under the State of Texas and Therefore are Unable to Treat Any Work Related Injuries.**

Have You Seen Another Doctor For This (Circle One)?    Yes    No

Name of Doctor: \_\_\_\_\_ City: \_\_\_\_\_ X-Rays \_\_\_\_\_  
Treatment: \_\_\_\_\_ MRI \_\_\_\_\_  
Results \_\_\_\_\_ CAT Scan \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If You Have Copies of Any Films or Imaging Reports That Relate to What You Are Seeking Treatment For, Please Provide These Documents to Our Office.

Are You Still Under This Doctor's Care (Circle One)?    Yes    No

When Was Your Last Physical? \_\_\_\_\_ Results \_\_\_\_\_

Please List Any Other Information That You Feel May Be Pertinent: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How Did You Hear About Us?**

Were You Referred By (Check All That Apply):

- Another Patient, Name of Patient \_\_\_\_\_
- Yellow Pages Ad
- Austin All Natural Magazine
- Website, Name of Site \_\_\_\_\_
- Other, \_\_\_\_\_