



Doctor's Initials

# Swanson Chiropractic & Acupuncture Clinics

## Patient Information

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

Patient Name (Legal): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Nickname (If Any): \_\_\_\_\_ Social Security No.: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Other: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Number of Children: \_\_\_\_\_ Ages of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_

Have you ever received Chiropractic Care?  No  Yes, Doctor's Name: \_\_\_\_\_

Who, or how were you referred to our office? \_\_\_\_\_

## Case History

Major Complaint: \_\_\_\_\_

When and How Complaint Began: \_\_\_\_\_

Activities of Daily Living affected by Health Complaint: \_\_\_\_\_

Previous Treatment:  None  MD  DC  PT  Heat  Ice  OTC  \_\_\_\_\_

Quality of Complaint/Pain:  Sharp  Dull  Achy  Burning  Stabbing  Throbbing  Stiff & Sore

Frequency of Complaint/Pain:  Off & On  Constant

Does the Complaint/Pain Radiate to Any Part of your Body?  No  Yes, Where to? \_\_\_\_\_

What Makes it Better?  Nothing  Rest  Ice  Heat  Movement  Stretching  OTC  \_\_\_\_\_

What Makes it Worse?  Nothing  Rest  Sitting  Standing  Movement  Overuse  \_\_\_\_\_

Grade Intensity/Severity of Complaint/Pain: [None] 0 1 2 3 4 5 6 7 8 9 10 [Worst Possible]

Doctor's Initials

Secondary Complaints: \_\_\_\_\_

Recent Accidents: \_\_\_\_\_

Recent Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

What are your goals for care in our office?  Short-term Relief  Long-term Relief  Wellness/Preventive Care

## Review of Systems

Please mark all of the following that apply.

Musculoskeletal:	Present	Past	Cardiovascular:	Present	Past	Respiratory:	Present	Past			
Jaw/TMJ Pain	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in Arm or Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Brain Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in Wrist or Hand	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cold/Flu	<input type="checkbox"/>	<input type="checkbox"/>			
Rib Pain	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cough/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>			
Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<b>Integumentary:</b>	Present	Past			
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>				Skin Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>				Skin Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in Leg or Knee	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in Ankle or Foot	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Legs	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergic/Immunologic:</b>	Present	Past			
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine:</b>	Present	Past				Hives	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replaced	<input type="checkbox"/>	<input type="checkbox"/>							Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	Allergy Shots	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Use	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Other Conditions:</b>	Present	Past	Menopausal	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary:</b>	Present	Past			
			Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>				<b>Hematologic/Lymphatic:</b>	Present	Past
Colicky Baby	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>						
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Burning Urination	<input type="checkbox"/>	<input type="checkbox"/>			
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>			
Torticollis/Wryneck	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>			
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal:</b>	Present	Past			
<b>Neurological:</b>	Present	Past	Fevers/Chills/Sweats	<input type="checkbox"/>	<input type="checkbox"/>				Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Headaches	<input type="checkbox"/>	<input type="checkbox"/>				<b>Ears/Nose/Throat:</b>	Present	Past
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>			
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Pinched Nerves	<input type="checkbox"/>	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric:</b>	Present	Past			
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<b>Eyes:</b>	Present	Past				Depression	<input type="checkbox"/>	<input type="checkbox"/>
<b>Constitutional:</b>	Present	Past							Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
						Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Energy Level Problem	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>						
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>									

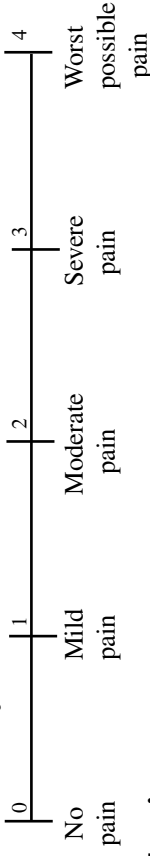


# Functional Rating Index

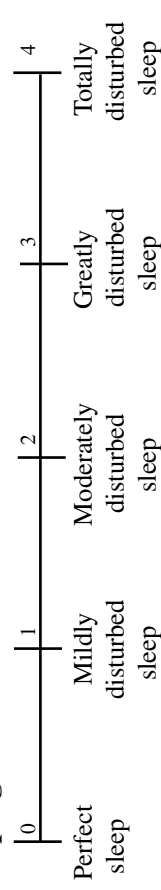
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

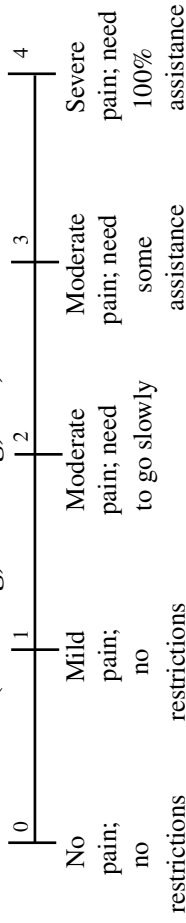
## 1. Pain Intensity



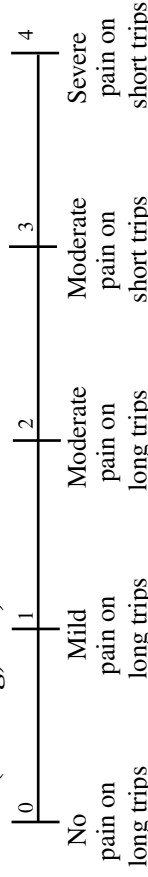
## 2. Sleeping



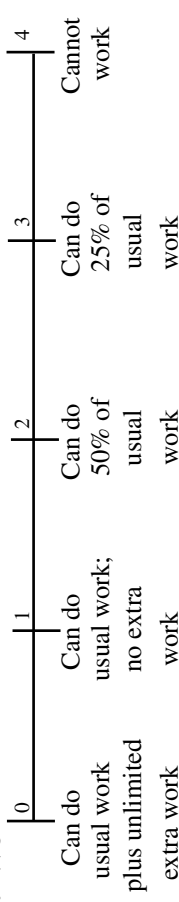
## 3. Personal Care (washing, dressing, etc.)



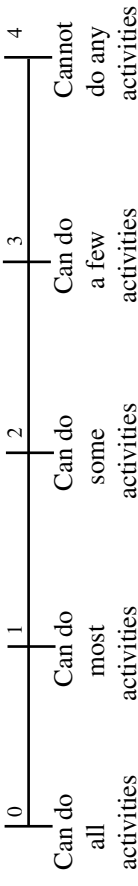
## 4. Travel (driving, etc.)



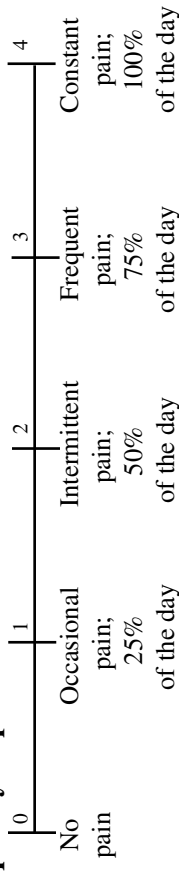
## 5. Work



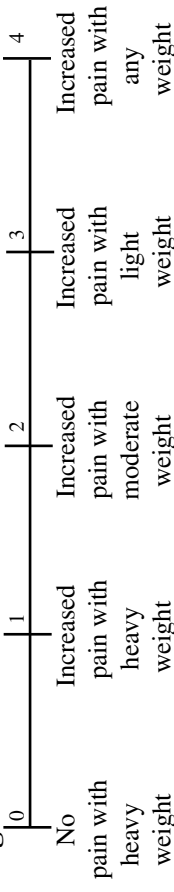
## 6. Recreation



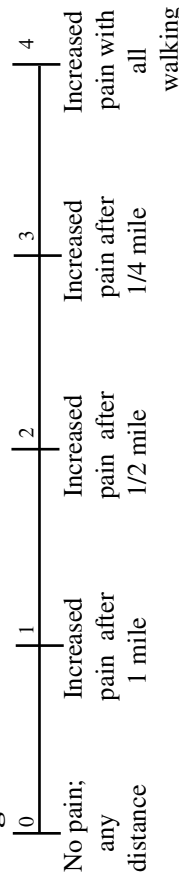
## 7. Frequency of pain



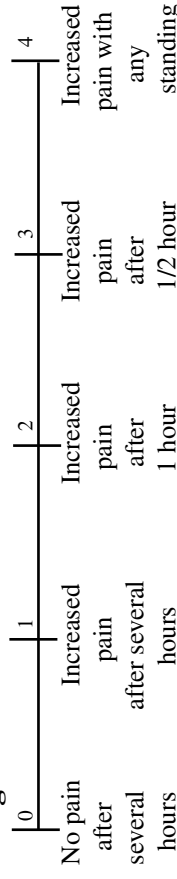
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_ ID#/SS# \_\_\_\_\_ Plan ID \_\_\_\_\_ Total Score \_\_\_\_\_

**PRINTED**

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Bee Cave Chiropractic & Acupuncture Clinic

Dr. Jon Swanson, D.C., F.A.S.A.

11805 FM 2244, Suite 500, Bee Cave, Texas 78738

Phone: 512.263.2233 Fax: 512.263.2295

## Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) 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 PHI 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 PHI. 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/her PHI 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 PHI. 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 Personal Health Information (PHI) in accordance with the Privacy Practices.

Patient or Guardian Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

## Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

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. In the event that your insurance company does not pay in a timely manner, 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 of Rights and Conveyance of Lien Interest**

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

**I instruct checks to be made payable to Bee Cave Chiropractic & Acupuncture Clinic, and payment to be sent to 11805 FM 2244, Suite 500, Bee Cave, Texas 78738.**

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. 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 and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Patient or Guardian Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent for 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".

• I, the undersigned parent or legal guardian of \_\_\_\_\_ (minor child), hereby give my permission to the staff of Austin Chiropractic & Acupuncture Clinic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Guardian Signature: X \_\_\_\_\_ Date: \_\_\_\_\_