Bee Cave Chiropractic & Acupuncture Clinic

11805 Bee Cave Rd., Suite 500
Bee Cave, Texas 78738
512-263-2233

Patient Information

Date:_____

Patient Name (Legal)**:**_____ **Date of Birth:**_____/_____/_____

Preferred Name (If Any)**:**_____ **Social Security No.:**_____-_____-_____

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

E-Mail Address:_____ **Home Phone:**_____

Mobile Phone:_____ **Preferred Method of Contact:** ☐ **Phone Call** ☐ **Text Message** ☐ **E-Mail**

Occupation:_____ **Employer:**_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Partnership** ☐ **Divorced** ☐ **Widowed**

Spouse's Name:_____ **Number of Children:**_____ **Age of Children:**_____

Emergency Contact:_____ **Contact Phone:**_____

Medical Doctor:_____ **Clinic Name:**_____

Have you ever received Chiropractic Care? ☐ **No** ☐ **Yes, Doctor's Name:**_____

Who can we thank for referring you for care? _____

Patient Case History

Major Complaint(s):_____

Complaint Began When and How? _____

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

What Daily Activities are affected by the Complaint? _____

Previous Treatment: ☐ **None** ☐ **MD** ☐ **PT** ☐ **Massage** ☐ **Heat** ☐ **Ice** ☐ **Meds** ☐ _____

Quality of Complaint/Pain: ☐ **Sharp** ☐ **Stabbing** ☐ **Shooting** ☐ **Numbness** ☐ **Tingling** ☐ **Weakness**
☐ **Gripping** ☐ **Burning** ☐ **Throbbing** ☐ **Stiffness** ☐ **Soreness** ☐ **Tenderness**

Frequency of Complaint/Pain: ☐ **Off & On** ☐ **Constant** **When is Complaint/Pain the worst?** ☐ **AM** ☐ **PM**

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** ☐ **Meds** ☐_____

What Makes it Worse? ☐ **Rest** ☐ **Sitting** ☐ **Standing** ☐ **Movement** ☐ **Overuse** ☐ **Stress** ☐_____

Secondary Complaint(s) (If Any):_____
What are your goals for care in our office? ☐ **Short-term Relief** ☐ **Long-term Relief** ☐ **Wellness/Preventive Care**

Current Medications:

☐ **None**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Past Health History – Major Injuries/Traumas:

☐ **None**

_____ _____
_____ _____
_____ _____

Past Health History - Surgeries/Hospitalizations:

☐ **None**

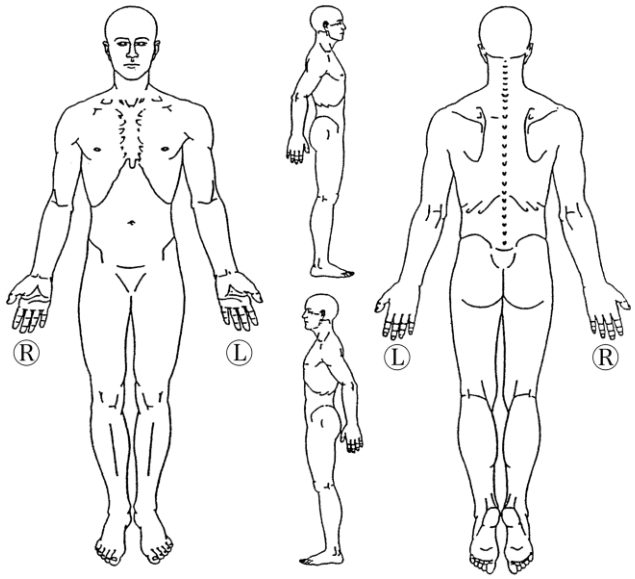
_____ _____
_____ _____
_____ _____

Family Health History - Relevant First Degree Relatives:

☐ **None**

_____ _____
_____ _____
_____ _____

MARK DIAGRAM WITH LOCATION OF COMPLAINTS



Lifestyle & Social History:

Current Use: ☐ **Caffeine** ☐ **Tobacco** ☐ **Marjiuana**
☐ **Alcohol** ☐ **Recreational Drugs**

Hobbies:_____
Recreation:_____
Exercise: _____
Diet: _____

Bee Chiropractic & Acupuncture Clinic
Dr. Jon Swanson
11805 Bee Cave Rd, Suite 500, Bee Cave, Texas, 78738
Phone: 512.263.2233 Fax: 512.263.2295

Patient Name: _____ D.O.B.: _____ Date: _____

Before this office begins any health care procedures we require you to read and sign this form stating you understand the below items. In the event you refuse to sign this form, the provider reserves the right to refuse care.

AUTHORIZATION: By signing below you authorize this office/provider to complete a consultation and examination for the above named patient.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you consent to the taking of x-rays if there is a determined need. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you have declared, to the best of your knowledge, there is no chance you are pregnant at this time.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you further acknowledge understanding that your health and motor vehicle insurance policies are an agreement between you and your carrier, and you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to be paid directly to this office/provider by your third-party payer, (e.g. insurance company, attorney, etc.). By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office. **I instruct checks to be made payable to Dr. Jon Swanson, and payment to be sent to 11805 Bee Cave Rd., Suite 500, Bee Cave, Texas, 78738.**

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature On File" or "SOF". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below you authorize this office to contact you for office related matters in the following manner: telephone (home, mobile, work), mobile text messaging, e-mail and postal mail. Messages may be left on an answering device/voicemail, or with the person answering your telephone. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), updated September 23, 2013, this office is required to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: examinations, chiropractic adjustments, supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify all the information given to this office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Patient Signature: X_____ Date: _____

Bee Cave Chiropractic & Acupuncture Clinic
Jon Swanson, D.C
11805 Bee Cave Road, Suite 500, Austin, Texas, 78738
Phone: 512.263.2233 Fax: 512.263.2295

Patient Name: _____ D.O.B.: _____ Date: _____

CONSENT FOR CHIROPRACTIC SERVICES

By reading below I have been made aware:

1. The process of delivering a "Chiropractic Adjustment (spinal manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (arms, legs, etc.), often resulting in an audible sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of motion, electricity, traction, heat, cold, bracing, or nutritional advice;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: X_____ Date: _____

Witness Signature:X_____ Date: _____