

WELCOME!

Today's Date _____

Name _____ Date of Birth _____ Phone _____

What do you prefer to be called? _____ Age _____ SS# _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer Name _____

Work Phone # _____ Employer's Address _____

Would you like to receive our free newsletter via e-mail? E-mail address _____

Marital Status: Single Divorced Married Spouse's Name _____

of children and ages _____

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

Have you ever been treated by a Chiropractor before? Yes No If so Whom? _____

For what condition: _____

INSURANCE INFORMATION

Insured's Name _____ Relation _____ Date of Birth _____

Insured's SS# _____ Insured's Employer _____

Your Ins. Co. _____ Group # _____

Ins Co. Address _____

Ins Co. Phone # _____

Person Ultimately Responsible for Account (Name and Address if different from above) _____

REASON FOR VISIT

The reason for this visit is a result of: Work Sports Auto Trauma Chronic

When did the condition begin? ___/___/___ The onset was: Gradual Sudden

What is your current primary problem? _____

Other problems? _____

Drs. Notes _____

What will cause your pain to **WORSEN**? _____

What gives you the **GREATEST RELIEF / CONTROL** of pain? _____

How long can you sit _____, stand _____, drive _____, walk _____

Do you have difficulty with? Dressing Personal Hygiene House / yard work Preparing meals

Are there any other activities of daily living that you are having difficulty with due to your presenting complaint(s)? _____

Please describe the pain and its location: _____

Dr. Paul D. Austin, DC, CCSP, DACNB

Austin Chiropractic Center, 362 S. McCaslin Blvd, Louisville, CO 80027

Patient Name: _____

Patient Account: _____

Is this condition getting worse? Yes No Constant Comes and Goes

Is there radiation or referral of pain to other areas? Yes No Where? _____

On a scale of 0-10 please rate your pain (0=no pain, 10=extreme pain) _____

Dr.'s. notes: _____

HISTORY

Previous Injuries: Auto Work Comp Other: _____ Date(s): _____

Same or similar symptoms: Yes No Previous Symptoms: _____

Previous treatment & diagnostic tests:

1. Dr. _____ Date of 1st office visit _____ X-Rays _____

Treatment: _____ % Improvement _____

2. Dr. _____ Date of 1st office visit _____ X-Rays _____

Treatment: _____ % Improvement _____

MRI _____ CT _____ EMG _____

Bone Density Scan _____

SYSTEM REVIEW / PAST MEDICAL HISTORY

	Current	Past		Current	Past		Current	Past
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Weakness / fatigue	<input type="checkbox"/>	<input type="checkbox"/>	High Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight change ↑ ↓	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pallor/cyanosis	<input type="checkbox"/>	<input type="checkbox"/>
Growing moles	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sweating	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to hot / cold	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (whirling)	<input type="checkbox"/>	<input type="checkbox"/>
Light bothers eyes	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Valve	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Poor balance	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery/Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst / hunger	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	Coldness: Hands Feet	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Gout <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/>	<input type="checkbox"/>	Bowel / bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Nervous	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Irritable/moody	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Crying spells	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Bones/Joints	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	HIV+/Aids	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal menses	<input type="checkbox"/>	<input type="checkbox"/>	Cancer type _____	<input type="checkbox"/>	<input type="checkbox"/>
Osteopenia/Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>						

Dr. Paul D. Austin, DC, CCSP, DACNB

Austin Chiropractic Center, 362 S. McCaslin Blvd, Louisville, CO 80027

Patient Name: _____

Patient Account: _____

Please List any other serious medical condition(s) you have or have ever had: _____

Dr's. notes: _____

Please list anything that you may be allergic to _____

Are you taking any of the following medications?

- Anti-Anxiety Antidepressants Pain Killers (Including Aspirin) Muscle Relaxants Insulin
- Blood Thinners Birth Control Pill Other _____

Family Health History: Please circle those applicable (M=Mother, F=Father, S=Sister, B=Brother, GP=Grandparent)

High Blood Pressure	M F S B GP	Diabetes	M F S B GP	Anemia	M F S B GP
Heart Disease	M F S B GP	Asthma, Emphysema	M F S B GP	Arthritis	M F S B GP
Thyroid Disease	M F S B GP	Migraine	M F S B GP	Cancer	M F S B GP
Kidney Disease	M F S B GP	Seizures	M F S B GP	Birthmarks	M F S B GP
Parents living / good health		Parent deceased M F Ages: _____		Cause _____	

Past surgical/hospital history:

Type: _____ Date(s): _____

Type: _____ Date(s): _____

HABITS & ACTIVITY

Do you or have you ever smoked? No Yes _____Packs per day Duration_____ Quit: _____ years ago

Do you or have you ever used alcohol? No Socially Daily Rarely Type _____

Do you drink caffeinated beverages? No Yes _____ cups/day: coffee tea cola decaffeinated _____

Regular Exercise? Yes No Activity and intensity: _____

How much water do you drink per day? _____ Do you feel you eat a well balanced diet? Yes No

Are you interested in a complete nutritional profile to assess your specific nutritional needs? Yes No

Drs. Notes: _____

IN THE EVENT OF EMERGENCY

Who should we contact? _____ Relation _____

Home Phone: _____ Work Phone: _____

Medical Doctor? _____ Phone: _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date _____

Dr. Paul D. Austin, DC, CCSP, DACNB

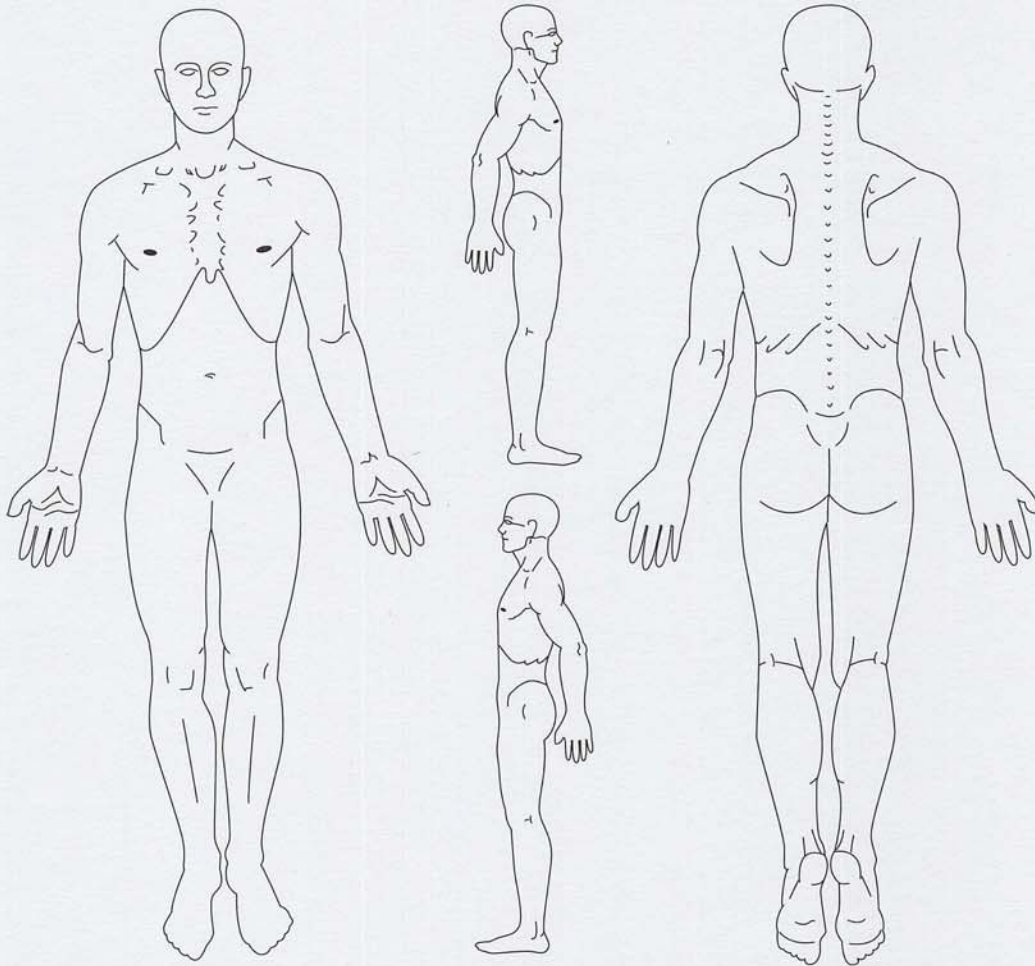
Patient Name: _____

Austin Chiropractic Center, 362 S. McCaslin Blvd, Louisville, CO 80027

Patient Account: _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

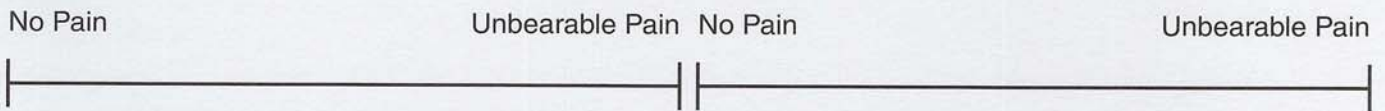
- D** = Dull
- B** = Burning
- N** = Numb
- S** = Stabbing/Cutting
- T** = Tingling (Pins & Needles)
- C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:

