Austin Sports Chiropractic
Patient Intake Form

PATIENT INFORMATION

First Name _____ MI ____ Last Name _____

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

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Gender: ____ M ____ F Date of Birth: _____ Social Security #: _____ - ____ - _____

Height: _____ Weight: _____ Marital Status: _____ # of Children _____

Emergency Contact: _____ Phone: _____

Emergency Contact Relationship: _____

EMPLOYMENT INFORMATION

_____ Full Time _____ Part Time _____ Student _____ Retired _____ Unemployed _____ Other

Employer Name: _____ Occupation: _____

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

Physical Work Duties: _____

Have you ever been to a chiropractor? ____ Yes ____ No
If so, who? _____

Purpose of your visit:

____ Wellness ____ Pain ____ Injury ____ Neurological Care ____ Performance Training

CURRENT COMPLAINTS

Have you had a car accident? ____ Yes ____ No Work accident? ____ Yes ____ No

Please describe the nature of your current complaint (location, intensity, quality, etc):

_____

When did this start? _____ How? _____

How frequent do you experience this? ____ Always ____ Hourly ____ Daily ____ Occasionally

Does this condition interfere with your daily activities? ____ Yes ____ No

Does this condition affect your sleep? ____ Yes ____ No How? _____

Does this condition affect your appetite? ____ Yes ____ No How? _____

Have you missed work due to this? ____ Yes ____ No How often? _____

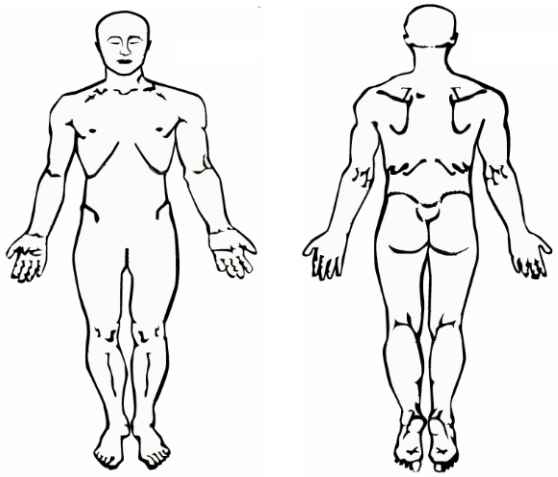
Is the condition worse/better at certain times of the day? ____ Yes ____ No
Explain: _____

Do certain movements or activities make your condition worse/better? ____ Yes ____ No
Explain: _____

Have you seen another medical professional for your current complaints? ____ Yes ____ No
If yes, where? _____

Have you ever experienced this condition at a prior time in your life? ____ Yes ____ No
If so, when? _____

Please place a letter at areas of pain or discomfort on the diagrams below:



Please rate any pain or discomfort on a scale of 1-10, with 10 being worst:
A _____ B _____ C _____ D _____ E _____ F _____ G _____ H _____ I _____ J _____ K _____

PERSONAL HEALTH HISTORY

Date of Last Physical Exam: _____ Name of Physician: _____

Physician Phone: _____ Physician City: _____ Physician State: ____

Please list conditions you have been treated for in the last 10 years:

_____

_____

Please list any hospitalizations in the last 10 years:

_____

_____

Please list all surgeries or operations:

_____

_____

List Current Medications and Dosages:

_____

_____

List Current Nutritional Supplements (please also include vitamins, minerals, and herbs):

_____

_____

Are you a smoker? ____ Yes ____ No _____ packs per day

How much alcohol do you consume per week? _____ drinks per week

How much exercise (greater than 30 mins) do you get per week? _____ times per week

What type of exercise? _____

By signing below I authorize Austin Sports Chiropractic and its staff to use the information provided herein to help make the best decisions for my care. I certify that the information provided is true and accurate to the best of my knowledge. I understand that Austin Sports Chiropractic does not accept insurance, Medicare, or payment from any third party. All payments are the responsibility of the patient and are due at the time of service unless otherwise agreed upon in writing by Austin Sports Chiropractic and the patient.

_____ _____

Patient/Guardian Date

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head	_____	Headaches
	_____	Faintness
	_____	Dizziness
	_____	Insomnia
		Total _____
Eyes	_____	Watery or Itchy Eyes
	_____	Swollen, Reddened or Sticky Eyelids
	_____	Bags or Dark Circles Under Eyes
	_____	Blurred or Tunnel Vision (does not include near or far-sighted)
		Total _____
Ears	_____	Itchy Ears
	_____	Earaches, Ear Infections
	_____	Drainage from Ear
	_____	Ringing in Ears, Hearing Loss
		Total _____
Nose	_____	Stuffy Nose
	_____	Sinus Problems
	_____	Hay Fever
	_____	Sneezing Attacks
	_____	Excessive Mucus Formation
		Total _____
Mouth/ Throat	_____	Chronic Coughing
	_____	Gagging, Frequent Need to Clear Throat
	_____	Sore Throat, Hoarseness, Loss of Voice
	_____	Swollen or Discolored Tongue, Gums, or Lips
	_____	Canker Sores
		Total _____
Skin	_____	Acne
	_____	Hives, Rashes, Dry Skin
	_____	Hair Loss
	_____	Flushing, Hot Flashes
	_____	Excessive Sweating
		Total _____
Heart	_____	Irregular or Skipped Heartbeat
	_____	Rapid or Pounding Heartbeat
	_____	Chest Pain
		Total _____

Lungs	_____	Chest Congestion
	_____	Asthma, Bronchitis
	_____	Shortness of Breath
	_____	Difficulty Breathing

Total _____

Digestion	_____	Nausea, Vomiting
	_____	Diarrhea
	_____	Constipation
	_____	Bloated Feeling
	_____	Belching, Passing Gas
	_____	Heartburn
	_____	Intestinal/Stomach Pain

Total _____

Joints/	_____	Pain or Aches in Joints
Muscles	_____	Arthritis
	_____	Stiffness or Limitation of Movement
	_____	Pain or Aches in Muscles
	_____	Feeling of Weakness or Tiredness

Total _____

Weight	_____	Binge Eating/Drinking
	_____	Craving Certain Foods
	_____	Excessive Weight
	_____	Compulsive Eating
	_____	Water Retention
	_____	Underweight

Total _____

Energy/	_____	Fatigue, Sluggishness
Activity	_____	Apathy, Lethargy
	_____	Hyperactivity
	_____	Restlessness

Total _____

Mind	_____	Poor Memory
	_____	Confusion, Poor Comprehension
	_____	Poor Concentration
	_____	Poor Physical Condition
	_____	Difficulty in Making Decisions
	_____	Stuttering or Stammering
	_____	Slurred Speech
	_____	Learning Disabilities

Total _____

Emotions	_____	Mood Swings
	_____	Anxiety, Fear, Nervousness
	_____	Anger, Irritability, Aggressiveness
	_____	Depression

Total _____

Other	_____	Frequent Illness
	_____	Frequent or Urgent Urination
	_____	Genital Itch or Discharge

Total _____

Grand Total _____

36-Item Short Form Survey Instrument (SF-36)

RAND 36-Item Health Survey 1.0 Questionnaire Items

Choose one option for each questionnaire item.

1. In general, would you say your health is:

- 1 - Excellent
- 2 - Very good
- 3 - Good
- 4 - Fair
- 5 - Poor

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2. **Compared to one year ago**, how would you rate your health in general **now**?

- 1 - Much better now than one year ago
- 2 - Somewhat better now than one year ago
- 3 - About the same
- 4 - Somewhat worse now than one year ago
- 5 - Much worse now than one year ago

The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	○ 1	○ 2	○ 3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○ 1	○ 2	○ 3
5. Lifting or carrying groceries	○ 1	○ 2	○ 3
6. Climbing **several** flights of stairs	○ 1	○ 2	○ 3
7. Climbing **one** flight of stairs	○ 1	○ 2	○ 3
8. Bending, kneeling, or stooping	○ 1	○ 2	○ 3
9. Walking **more than a mile**	○ 1	○ 2	○ 3
10. Walking **several blocks**	○ 1	○ 2	○ 3
11. Walking **one block**	○ 1	○ 2	○ 3
12. Bathing or dressing yourself	○ 1	○ 2	○ 3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	Yes	No
13. Cut down the **amount of time** you spent on work or other activities	1	2
14. **Accomplished less** than you would like	1	2
15. Were limited in the **kind** of work or other activities	1	2
16. Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
17. Cut down the **amount of time** you spent on work or other activities	1	2
18. **Accomplished less** than you would like	1	2
19. Didn't do work or other activities as **carefully** as usual	1	2

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- 1 - Not at all
- 2 - Slightly
- 3 - Moderately
- 4 - Quite a bit
- 5 - Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**?

- 1 - None
- 2 - Very mild
- 3 - Mild
- 4 - Moderate
- 5 - Severe
- 6 - Very severe

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22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- 1 - Not at all
- 2 - A little bit
- 3 - Moderately
- 4 - Quite a bit
- 5 - Extremely

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

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32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- 1 - All of the time
- 2 - Most of the time
- 3 - Some of the time
- 4 - A little of the time
- 5 - None of the time

How TRUE or FALSE is **each** of the following statements for you.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

ABOUT

The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

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Santa Monica, California 90401-3208

PRECISION
CHIROPRACTIC

Diagnostic Imaging and X-Ray Consent

Patient Name: _____
DOB:_____

Are you pregnant or is there any chance you may be pregnant?

_____ Yes

_____ No

The exam that your doctor has ordered uses ionizing radiation which can have negative effects to the unborn baby during pregnancy. The extent of health effect depends on the gestational age at the time of exposure and the amount of radiation that is delivered and exposed. Unborn babies are especially sensitive to ionizing radiation during weeks 2-15 of pregnancy. Consequences can include stunted growth, deformities, abnormal brain function, or cancer that could develop later in life. You should speak with your doctor if you believe you may be pregnant to discuss possible side effects and the risks/benefits of this procedure. If you think that you could be pregnant, please inform the doctor before the exam to discuss alternative diagnostic procedures.

_____ To the best of my knowledge I am not pregnant and do not believe that there is any chance that I may be pregnant.

_____ I understand the risks and possible effects of ionizing radiation on an unborn baby.

Signature: _____
Date: _____