TEXSTAR CHIROPRACTIC
AUSTIN | BEE CAVE | BUDA | DRIPPING SPRINGS

Name: _____ Date: _____ File #: _____ Case Type: _____

Sex: _____ Birth Date: _____ Age: _____ Social Security #: _____

Address: _____ _____ _____ _____
Residence and Mailing | City | State | Zip Code

Home Phone: _____ Mobile Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Marital Status: ☐S ☐M ☐D ☐W Spouse's Name: _____ Spouse's Birth Date: _____

No. of Children: _____ Emergency Contact: _____ Contact Phone: _____

How did you hear about us? ☐ Google ☐ Another Patient (Please Name) _____

☐ Online Videos ☐ Social Media ☐ Doctor Referral (Please Name) _____

☐ Office Sign ☐ Insurance Co. ☐ Other (Please List) _____

Primary (First) Complaint and Location

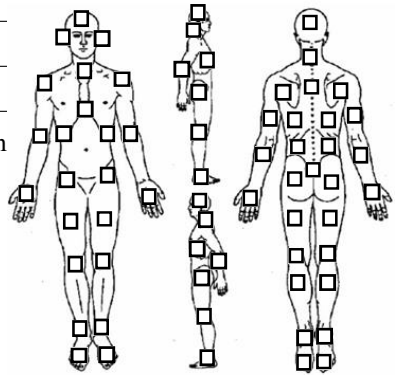
Chief Complaint/Body Area (Reason for Visit): _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Please ☑ the box on the where you have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Please describe your symptoms:

☐ Sharp ☐ Shooting ☐ Stiffness
☐ Dull ☐ Burning ☐ Deadness
☐ Throbbing ☐ Tingling ☐ Stabbing
☐ Aching ☐ Cramping ☐ Numb ☐ Excruciating ☐ Pulsating

What makes it worse?

☐ Sitting ☐ Lifting ☐ Driving ☐ Looking Down ☐ Sneezing
☐ Standing ☐ Coughing ☐ Walking ☐ Rotating Head ☐ Carrying
☐ Bending ☐ Straining ☐ Exercising ☐ Stress ☐ Climbing Stairs
☐ Lying Down ☐ Getting out of bed ☐ Looking Up ☐ Bright Lights ☐ Repetitive Movement

What makes it better?

☐ Ice ☐ Rest ☐ Pain Medications ☐ Lying Down ☐ Exercising
☐ Heat ☐ Tylenol ☐ Mineral Ice ☐ Sleeping ☐ Anti-inflammatory
☐ Massage ☐ Advil ☐ Muscle Relaxers Other: _____

What time of day is it worse? ☐ Morning ☐ End of day ☐ Night ☐ Various Times

What percentage of the day is the condition present? ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ None

Have you seen other doctors for this condition? ☐ Yes ☐ No If yes, who? (Name) _____

Type of Treatment: _____ Are you satisfied with the results of the treatment? ☐ Yes ☐ No

Primary Care Physician: _____ Have you ever had Chiropractic care before? ☐ Yes ☐ No

May we communicate with your Primary Care Physician about your care? ☐ Yes ☐ No

Do you exercise?	☐ None	☐ Infrequent	☐ Regular	☐ Frequent and Heavy				
Sufficient rest	☐ Never	☐ Rarely	☐ Occasionally	☐ Moderately				
Hours of sleep	☐ 3-4	☐ 5-6	☐ 7-8	☐ 9-10	☐ More than 10			
Personal stress	☐ Low	☐ Medium	☐ High	☐ Very high				
Occupational stress	☐ Low	☐ Medium	☐ High	☐ Very high				
Well-balanced diet	☐ Never	☐ Rarely	☐ Occasionally	☐ Regularly				
Do you smoke?	☐ No	☐ Occasionally	☐ 1 to 5	☐ 6 to 10	☐ 11-15	☐ Packs per day?		
Do you drink alcohol?	☐ No	☐ Occasionally	☐ 1 to 2	☐ 2 to 3	☐ 4 to 5	☐ More than 5 per day		
Do you drink caffeine?	☐ No	☐ Occasionally	☐ 1 to 2	☐ 2 to 3	☐ 4 to 5	☐ More than 5 per day		

Secondary Complaint and Location

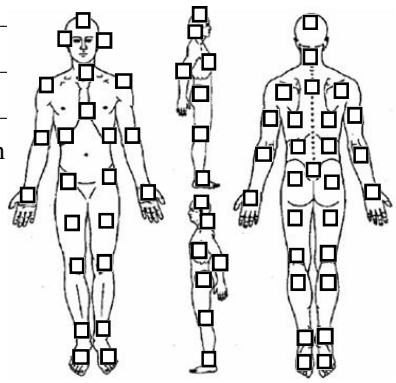
Second Complaint/Body Area: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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☐ Sharp	☐ Shooting	☐ Stiffness		
☐ Dull	☐ Burning	☐ Deadness		
☐ Throbbing	☐ Tingling	☐ Stabbing		
☐ Aching	☐ Cramping	☐ Numb	☐ Excruciating	☐ Pulsating

What makes it worse?

☐ Sitting	☐ Lifting	☐ Driving	☐ Looking Down	☐ Sneezing
☐ Standing	☐ Coughing	☐ Walking	☐ Rotating Head	☐ Carrying
☐ Bending	☐ Straining	☐ Exercising	☐ Stress	☐ Climbing Stairs
☐ Lying Down	☐ Getting out of bed	☐ Looking Up	☐ Bright Lights	☐ Repetitive Movement

What makes it better?

☐ Ice	☐ Rest	☐ Pain Medications	☐ Lying Down	☐ Exercising
☐ Heat	☐ Tylenol	☐ Mineral Ice	☐ Sleeping	☐ Anti-inflammatory
☐ Massage	☐ Advil	☐ Muscle Relaxers	Other: _____	

What time of day is it worse? ☐ Morning ☐ End of day ☐ Night ☐ Various Times

What percentage of the day is the condition present? ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ None

Third Complaint and Location

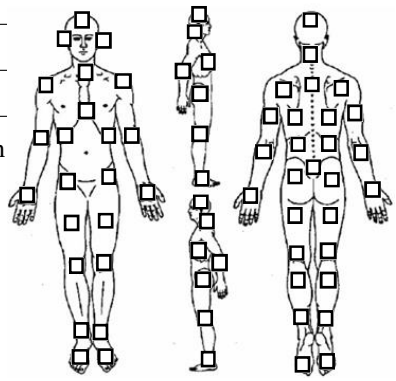
Third Complaint/Body Area: _____

When did your symptoms appear (Onset Date)? _____

Please describe the cause of the injury: _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



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Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ None

Past Health History

Below is a list of conditions that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Neurological Health History

☐ Facial Weakness ☐ Loss of Balance ☐ Sensation Loss ☐ Memory Loss
☐ Smell Disturbance ☐ Stroke ☐ Incontinence ☐ Dizziness
☐ Speech Disturbance ☐ Seizures _____ ☐ Ringing in Ears ☐ Nervousness
☐ Visual Disturbance ☐ Numbness in Toes ☐ Headaches ☐ Stomach Upset
☐ Loss of Taste ☐ Numbness in Fingers ☐ Irritability ☐ Tension

Musculoskeletal Health History

☐ Abnormal Posture ☐ Disc Herniation ☐ Osteopenia ☐ Elbow Problem
☐ Osteoarthritis ☐ Degenerative Disc Disease ☐ Osteoporosis ☐ Wrist Problem
☐ Dislocation/Fracture ☐ Shoulder Problem _____ ☐ TMJ Syndrome ☐ Ankle Problem
☐ Lower Back Pain ☐ Knee Problem _____ ☐ Headaches ☐ Pes Planus
☐ Neck Pain ☐ Sprain/Strain _____ ☐ Tendonitis _____ Other _____

Childhood Illnesses

- [ ] ADD / ADHD
- [ ] Allergies / Hay Fever
- [ ] Asthma
- [ ] Eczema
- [ ] Cerebral Palsy
- [ ] Chicken Pox
- [ ] Depression
- [ ] Diabetes (Type I)
- [ ] Fetal Drug Exposure
- [ ] Food Allergies
- [ ] Headaches
- [ ] Hepatitis
- [ ] Measles
- [ ] Mumps
- [ ] Rash
- [ ] Scoliosis
- [ ] Sickle Cell Anemia
- [ ] Ear infections
- [ ] Other _____
- [ ] Bed Wetting

Adult Illnesses

- [ ] Alzheimer's
- [ ] Anemia
- [ ] CRPS (RSD)
- [ ] Cancer _____
- [ ] Chicken Pox
- [ ] Crohn's / Colitis
- [ ] Heart Disease
- [ ] Kidney Problems
- [ ] Depression
- [ ] Diabetes (Type II)
- [ ] Liver Disease
- [ ] Emphysema
- [ ] Eye Problems
- [ ] Fibromyalgia
- [ ] Parkinson's Disease
- [ ] STD's (unspecified)
- [ ] Hypertension
- [ ] Pneumonia
- [ ] Seizure Disorder
- [ ] Hepatitis
- [ ] Lupus Erythema
- [ ] Multiple Sclerosis
- [ ] Vertigo
- [ ] Other _____
- [ ] Psychiatric Problems
- [ ] Scoliosis
- [ ] Asthma
- [ ] Suicide Attempt(s)
- [ ] Thyroid Problems
- [ ] Ear Infections (frequent)

Past Surgeries

- [ ] Angioplasty
- [ ] Appendectomy
- [ ] Ceaserian Section
- [ ] Carpal Tunnel Repair
- [ ] Coronary Artery Bypass
- [ ] Cosmetic
- [ ] D & C
- [ ] Rotator Cuff
- [ ] Hemorrhoidectomy
- [ ] Hernia Repair
- [ ] Hysterectomy
- [ ] Gallbladder
- [ ] Laminectomy _____
- [ ] Mastectomy
- [ ] Pacemaker Insertion
- [ ] Knee Replacement
- [ ] Spinal Fusion _____
- [ ] Tympanostomy
- [ ] Cardiac Catherization
- [ ] Hip Replacement
- [ ] Other _____

_____

Current Medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

Vitamins and Supplements

_____ _____ _____

_____ _____ _____

_____ _____ _____

Known Drug Allergies

_____ _____ _____

_____ _____ _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

Signature (Patient or Guardian) *Date*

Financial / Insurance Information

Who is responsible for this account? _____Relationship to patient: _____

Health Insurance Company Name: _____2nd Ins. Co. Name: _____

Please be aware of the following: If you have an HMO, you will need a referral from your Primary Care Doctor. Also, some plans require a Pre-Authorization after the Initial Exam and Report of Findings.

Denial of Work/Auto Accident

I confirm that the treatment I am requesting to receive today is NOT for injuries sustained in an automobile accident or work-related accident.

_____ _____

Signature (Patient or Guardian) *Date*

Auto Accident Information

If you were in a Motor Vehicle Accident, please list YOUR Auto Insurance information:
(We do not bill 3rd Party Automobile Insurance Companies. See MVA Financial Policies Page for details.)

Auto Insurance Company Name: _____ Phone # _____

Claim #: _____Adjuster Name: _____Phone # _____

Financial Policies / Fee Schedule

I understand that health and accident policies are an arrangement between my insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collections from my insurance company. **Ultimately, I am responsible for all services rendered, including those not reimbursed by my insurance company.**

Services	**Fees**
Initial 5-minute Consultation	Complimentary
New Patient Exam	$115.00
X-Rays, 2-3 view, 1 area	$68.00
Progress Exam	$76.00
Care Coordination and Counseling	$40.00
Chiropractic Spinal Adjustment	$68.00
Interferential Stimulation Therapy	$54.00
Intersegmental Traction Therapy	$29.00
Therapeutic Exercises/Rehab	$54.00
MLS Cold Laser (per body area)	$78.00
Spot Cryo Therapy	$52.00
Non-Surgical Spinal Decompression	$88.00
Kinesio Taping	$29.00
Per Visit Admin Fee	$2.00

I have read and understand the above financial policies.

_____ _____

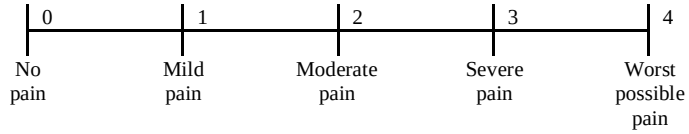
Signature (Patient or Guardian) *Date*

Functional Rating Index

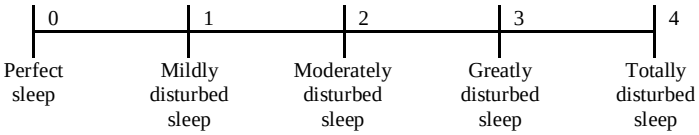
For use with **Neck and/or Back Problems** only.

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

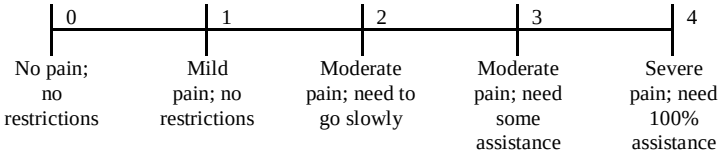
1. Pain Intensity



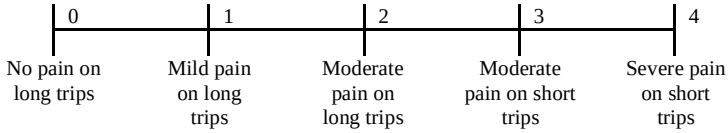
2. Sleeping



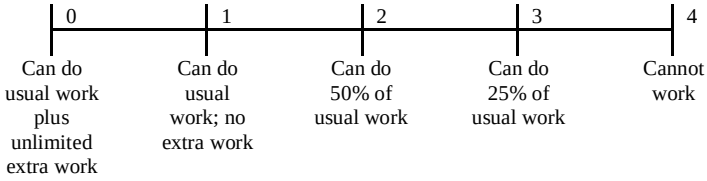
3. Personal Care (washing, dressing, etc.)



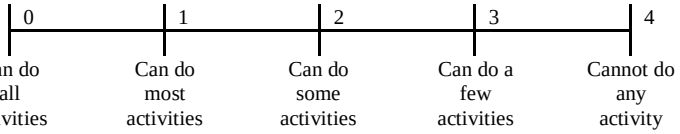
4. Travelling (driving, etc.)



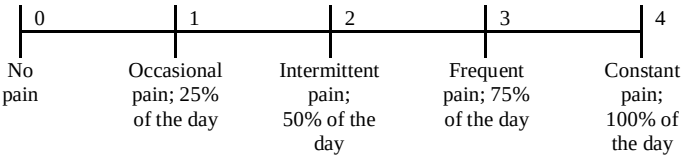
5. Work



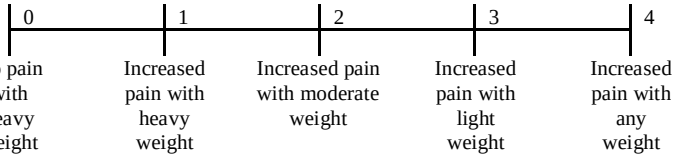
6. Recreation



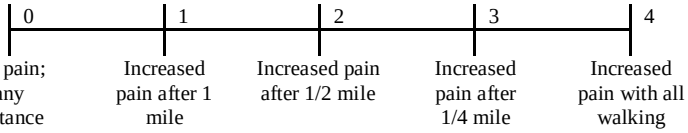
7. Frequency of Pain



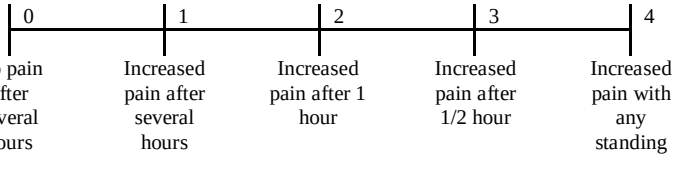
8. Lifting



9. Walking



10. Standing



_____ _____

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____/ 40

Clinical Diagnosis Codes:

Patient ID#:_____