# 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:**_____ **Health Insurance Company:**_____

**Occupation:**_____ **Employer:**_____

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

**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 referred you or how did you find our office?** _____

## Chiropractic Case History

**Major Complaint:**_____

**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** ☐ **DC** ☐ **PT** ☐ **Heat** ☐ **Ice** ☐ **OTC** ☐ _____

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

**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** ☐ **OTC** ☐ _____

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

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 |
|---|---|---|
| Jaw/TMJ Pain | ☐ | ☐ |
| Neck Pain | ☐ | ☐ |
| Shoulder Pain | ☐ | ☐ |
| Pain in Arm or Elbow | ☐ | ☐ |
| Pain in Wrist or Hand | ☐ | ☐ |
| Rib Pain | ☐ | ☐ |
| Upper Back Pain | ☐ | ☐ |
| Mid Back Pain | ☐ | ☐ |
| Lower Back Pain | ☐ | ☐ |
| Hip Pain | ☐ | ☐ |
| Pain in Leg or Knee | ☐ | ☐ |
| Pain in Ankle or Foot | ☐ | ☐ |
| Joint Stiffness | ☐ | ☐ |
| Muscle Weakness | ☐ | ☐ |
| Joint Replaced | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Broken Bones | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |

| Other Conditions: | Present | Past |
|---|---|---|
| Ear Infections | ☐ | ☐ |
| Colicky Baby | ☐ | ☐ |
| Bed Wetting | ☐ | ☐ |
| Acid Reflux | ☐ | ☐ |
| Torticollis/Wryneck | ☐ | ☐ |
| Whiplash | ☐ | ☐ |

| Neurological: | Present | Past |
|---|---|---|
| Headaches | ☐ | ☐ |
| Dizziness | ☐ | ☐ |
| Numbness | ☐ | ☐ |
| Pinched Nerves | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Head Injury | ☐ | ☐ |
| Parkinson's Disease | ☐ | ☐ |

| Constitutional: | Present | Past |
|---|---|---|
| Weight Loss/Gain | ☐ | ☐ |
| Energy Level Problem | ☐ | ☐ |
| Difficulty Sleeping | ☐ | ☐ |

| Cardiovascular: | Present | Past |
|---|---|---|
| Poor Circulation | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Aortic Aneurism | ☐ | ☐ |
| Brain Aneurysm | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ |
| Pace Maker | ☐ | ☐ |
| Jaw Pain | ☐ | ☐ |
| Irregular Heartbeat | ☐ | ☐ |
| Swelling of Legs | ☐ | ☐ |

| Endocrine: | Present | Past |
|---|---|---|
| Thyroid Disease | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Hair Loss | ☐ | ☐ |
| Menstrual Problems | ☐ | ☐ |
| Menopausal | ☐ | ☐ |

| Hematologic/Lymphatic: | Present | Past |
|---|---|---|
| Hepatitis | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Blood Clots | ☐ | ☐ |
| Easy Bruising | ☐ | ☐ |
| Easy Bleeding | ☐ | ☐ |
| Fevers/Chills/Sweats | ☐ | ☐ |

| Ears/Nose/Throat: | Present | Past |
|---|---|---|
| Tinnitus | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ |
| Balance Problems | ☐ | ☐ |
| Sinus Infection | ☐ | ☐ |
| Nosebleed | ☐ | ☐ |
| Sore Throat | ☐ | ☐ |
| Difficulty Swallowing | ☐ | ☐ |
| Bleeding Gums | ☐ | ☐ |

| Eyes: | Present | Past |
|---|---|---|
| Glaucoma | ☐ | ☐ |
| Double Vision | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ |

| Respiratory: | Present | Past |
|---|---|---|
| Asthma | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Cold/Flu | ☐ | ☐ |
| Cough/Wheezing | ☐ | ☐ |

| Integumentary: | Present | Past |
|---|---|---|
| Skin Lesions | ☐ | ☐ |
| Skin Ulcers | ☐ | ☐ |
| Skin Disease | ☐ | ☐ |
| Eczema | ☐ | ☐ |
| Psoriasis | ☐ | ☐ |

| Allergic/Immunologic: | Present | Past |
|---|---|---|
| Hives | ☐ | ☐ |
| Immune Disorder | ☐ | ☐ |
| HIV/AIDS | ☐ | ☐ |
| Allergy Shots | ☐ | ☐ |
| Cortisone Use | ☐ | ☐ |

| Genitourinary: | Present | Past |
|---|---|---|
| Kidney Disease | ☐ | ☐ |
| Lower Side Pain | ☐ | ☐ |
| Burning Urination | ☐ | ☐ |
| Blood in Urine | ☐ | ☐ |
| Kidney Stone | ☐ | ☐ |

| Gastrointestinal: | Present | Past |
|---|---|---|
| Gallbladder Problems | ☐ | ☐ |
| Bowel Problems | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Liver Problems | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Nausea/Vomiting | ☐ | ☐ |
| Bloody Stools | ☐ | ☐ |
| Poor Appetite | ☐ | ☐ |

| Psychiatric: | Present | Past |
|---|---|---|
| Depression | ☐ | ☐ |
| Anxiety Disorder | ☐ | ☐ |
| Unusual Stress | ☐ | ☐ |

Doctor's Initials

# Past & Social History

*Please mark all of the following that apply.*

| Medical Conditions: | | Allergies: | | Recreational Activites: | |
|---|---|---|---|---|---|
| Arthritis | ☐ | Seasonal Allergies | ☐ | Backpacking/Hiking | ☐ |
| Cancer | ☐ | Eggs | ☐ | Basketball | ☐ |
| Diabetes | ☐ | Fish and Shellfish | ☐ | Baseball | ☐ |
| Heart Disease | ☐ | Milk or Lactose | ☐ | Biking | ☐ |
| Hypertension | ☐ | Peanut | ☐ | Boating | ☐ |
| Psychiatric Illness | ☐ | Sulfites | ☐ | Dancing | ☐ |
| Skin Disorder | ☐ | Wheat/Gluten | ☐ | Football | ☐ |
| Stroke | ☐ | | | Golf | ☐ |
| Tumor | ☐ | **Occupational Activities:** | | Racket Ball | ☐ |
| Other: | ☐ | Administration | ☐ | Running | ☐ |
| | | Business Owner | ☐ | Skiing | ☐ |
| **Surgeries:** | | Clerical/Secretarial | ☐ | Soccer | ☐ |
| Appendectomy | ☐ | Computer User | ☐ | Swimming | ☐ |
| Cardiovascular Procedure | ☐ | Construction | ☐ | Tennis | ☐ |
| Cervical Disc Procedure | ☐ | Daycare/Childcare | ☐ | Walking | ☐ |
| Hysterectomy | ☐ | Executive/Legal | ☐ | Weight Lifting | ☐ |
| Joint Replacement | ☐ | Food Service Industry | ☐ | Other: | ☐ |
| Laminectomies | ☐ | Healthcare | ☐ | | |
| Lumbar Disc Procedure | ☐ | Heavy Equipment Operator | ☐ | **Social History:** | |
| Prostate Surgery | ☐ | Heavy Manual Labor | ☐ | Caffeine Use Occasionally | ☐ |
| Other: | ☐ | Home Services | ☐ | Caffeine Use Often | ☐ |
| | | Household | ☐ | Chew Tobacco Occasionally | ☐ |
| **Family History:** | *Parent* *Sibling* | Light Manual Labor | ☐ | Chew Tobacco Often | ☐ |
| Arthritis | ☐ ☐ | Manufactoring | ☐ | Drink Alcohol Occasionally | ☐ |
| Cancer | ☐ ☐ | Medium Manual Labor | ☐ | Drink Alcohol Often | ☐ |
| Cholesterol | ☐ ☐ | Military | ☐ | Exercise Not At All | ☐ |
| Diabetes | ☐ ☐ | Police/Fire | ☐ | Exercise Occasionally | ☐ |
| Heart Problems | ☐ ☐ | Professional Services | ☐ | Exercise Often | ☐ |
| High Blood Pressure | ☐ ☐ | Retail Worker | ☐ | Experience Stress Occasionally | ☐ |
| Psychiatric | ☐ ☐ | Teacher | ☐ | Experience Stress Often | ☐ |
| Stroke | ☐ ☐ | Truck Driver | ☐ | Smoke Cigarettes Occasionally | ☐ |
| Thyroid | ☐ ☐ | Other: | ☐ | Smoke Cigarettes Often | ☐ |

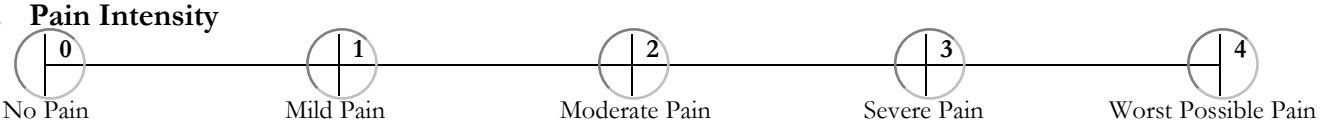
**Additional Notes:**_____

Doctor's Initials

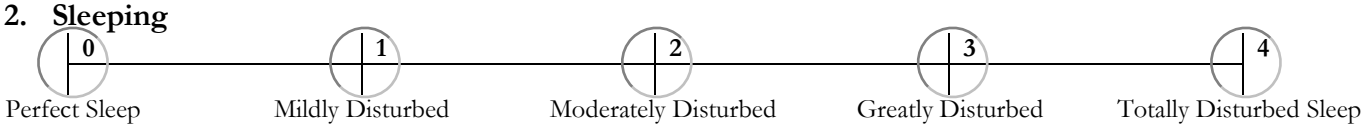
# Functional Rating Index

**For each item below, please circle the number, 0 – 4, which most closely describes your condition right now.**

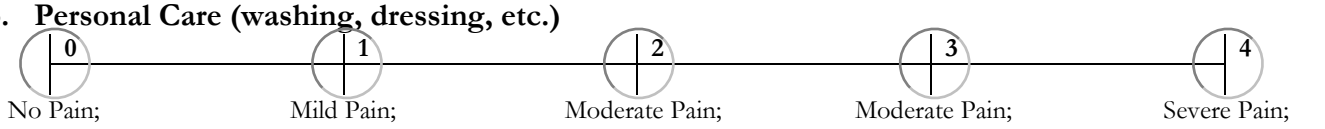
**1. Pain Intensity**



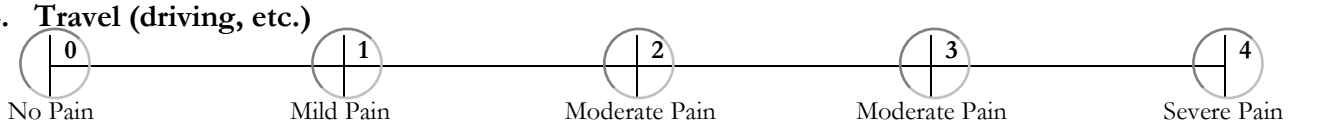

**2. Sleeping**



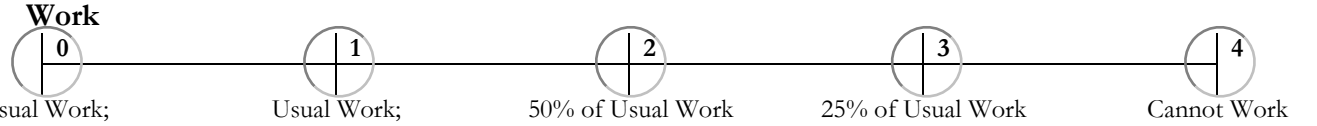

**3. Personal Care (washing, dressing, etc.)**



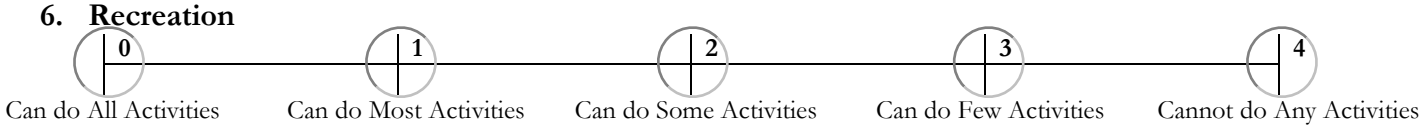

**4. Travel (driving, etc.)**



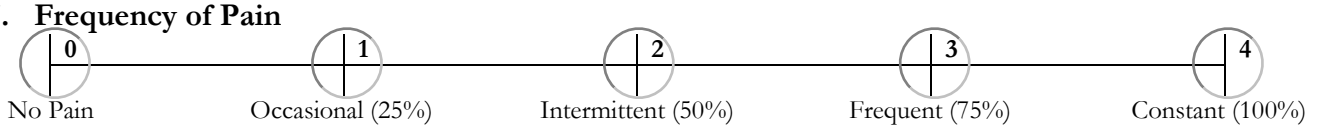

**5. Work**



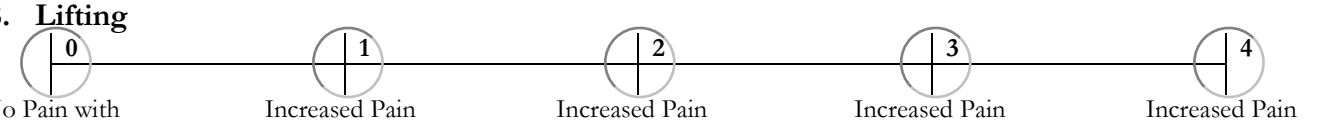

**6. Recreation**



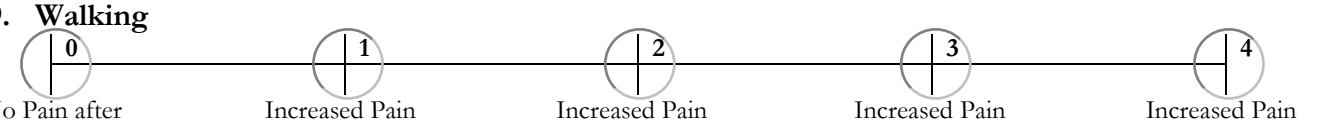

**7. Frequency of Pain**



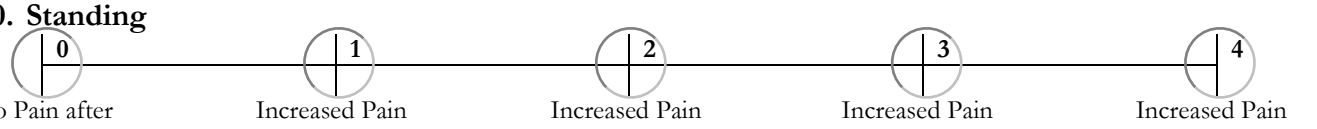

**8. Lifting**




**9. Walking**




**10. Standing**




Patient or Guardian Signature: X_____ Date: _____

Functional Rating Index Score: _____% (Completed by Dr. Swanson.)

# 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 Dr. Jon Swanson, 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). I also instruct my attorney to provide a disbursement letter showing full accounting to the above doctor upon request.

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". **Other known side effects are: Increased health and vitality, improved resistance to dis-ease and sickness, and a heightened sense of well being.**

* If patient is a minor: I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of Bee Cave Chiropractic & Acupuncture Clinic to treat said minor.

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: _____

**Please Print OR E-Mail Paperwork**

**info@beecavechiro.com**