1900 Cypress Creek Rd. Suite 101
Cedar Park, TX 78613
512-250-2224

GATEWAY TO WELLNESS
GETTING YOU BACK TO WHAT YOU LOVE

Name: _____ **Date:** _____

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

Cell Phone (____)_____**Home (____)**_____ **Work (____)**_____

Email Address: _____**Male**_____**Female**_____

Birth Date: _____ **Age**_____

Occupation: _____ **Employer Name**_____

Single____ **Married**____ **Spouse's Name** _____

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

YOUR HEALTH SUMMARY

What is your chief complaint?_____

Have you seen a Chiropractor before? _____ **If yes, when?**_____

Check all symptoms you have ever had even if they do not seem related to your current problem.

___Headaches	___Pins and Needles in legs	___Neck Pain	___Dizziness
___Pins and needles in arms	___Back Pain	___Loss of balance	___Fatigue
___Ringing in ears	___Numbness in fingers	___Numbness in toes	___Cold Feet
___Depression	___Tension	___Menstrual irregularity	___Cold Hands
___Sleeping problems	___Neck Stiffness	___Heartburn	___Vertigo
___Migraines	___Problem Urinating	___TMJD	___Shoulder Pain

Please list any medications you are taking: _____

_____

If this is due to an injury or auto accident, what is the date of injury or accident?_____

Has this problem been getting better, worse, or staying the same?_____

What activities make your condition worse? _____

Any surgeries or hospitalizations?_____

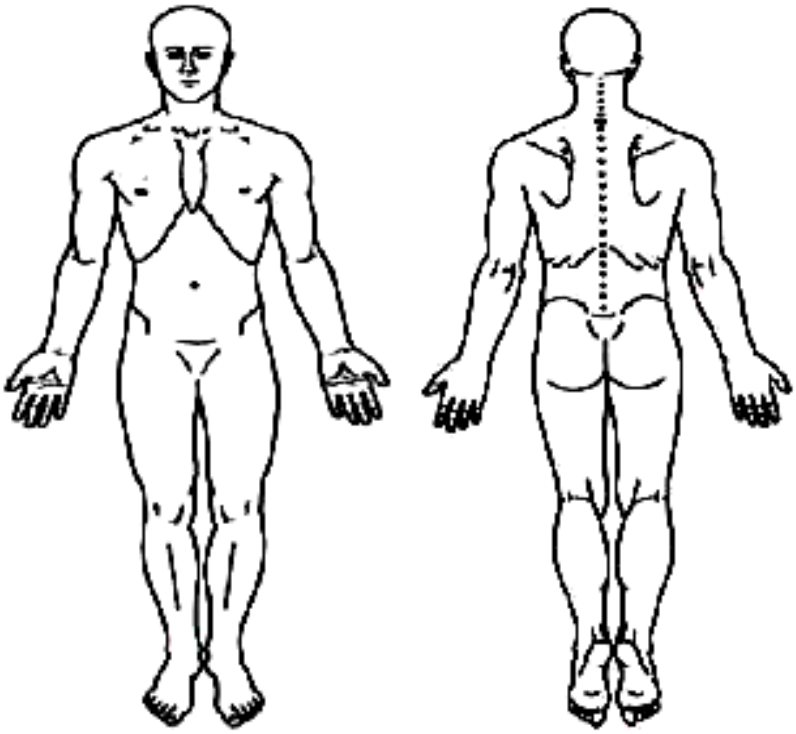
Injuries or illnesses that you have had that are not listed above:_____

Do you have health insurance? □ Yes □ No Or a HSA account? □ Yes □ No

If so, please provide the front desk with your card so we can verify your benefits with our office.

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, *dull, sharp, constant, off and on, when standing, when sitting, etc., etc.*

COMPLETE THESE DIAGRAMS



NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE OR VERIFY A DIAGNOSIS, TYPE OF TREATMENT AND LENGTH OF TREATMENT. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

Texas state law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, and provide care in an open door adjusting environment. As a result patients are in sight of each other, and some ongoing / routine details of care may be in ear shot of other patients and staff. This environment is used for ongoing care and is not the environment for taking patient's histories, performing examinations, or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open door adjusting environment, other arrangements will be made for you. Your signature below authorizes us to contact you at all phone numbers / addresses you list on this intake form. If you do not wish to be contacted at any listed numbers / addresses, please let us know.

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.
Please initial to indicate you have been made aware of its availability: _____

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.

Patient's Signature_____Date_____

Functional Rating Index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities.
For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity: No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Pain Ever

2. Sleeping: Perfect Sleep | Mildly Disturbed Sleep | Moderately Disturbed Sleep | Greatly Disturbed Sleep | Totally Disturbed Sleep

3. Personal Care (washing, dressing, ets.):
No Pain No Restrictions | Mild Pain No Restrictions | Moderate Pain Need To Go Slowly | Moderate Pain Need Some Assistance

4. Travel (driving, etc.):
No Pain On Long Trips | Mild Pain On Long Trips | Moderate Pain On Long Trips | Moderate Pain On Short Trips | Severe Pain on Short Trips

5. Work:
Usual Work Plus Extra | Usual Work No Extra | 50% of Usual Work | 25% of Usual Work | Cannot Work

6. Recreation: No Pain | Mild Pain | Moderate Pain | Severe Pain | Worst Possible Pain

7. Frequency of Pain:
No Pain | Pain 25% Of The Day | Pain 50% Of The Day | Pain 75% Of The Day | Pain 100% Of The Day

8. Lifting:
No Pain | Pain w/Heavy Weight | Pain w/Moderate Weight | Pain w/Light Weight | Pain w/Any Weight

9. Walking:
No Pain | Pain after 1 Mile | Pain after ½ Mile | Pain after ¼ Mile | Pain with All Walking

10. Standing:
No Pain | Pain after Several Hours | Pain after 1 Hour | Pain after ½ Hour | Pain with Any Standing