



To Our Prospective/Returning Patients:

In this packet you will find the necessary information sheets to help us give you the best options for care at our clinic.

If you only have low back pain, or only neck pain, then please fill out the appropriate Pain Index form. Or, if your symptoms are in the neck *and* low back areas, please fill out *both* Pain Index forms.

The Motor Vehicle Accident form will only be needed if you have had a recent motor vehicle accident.

Please fax or send all forms to us at 512/231-1087; or scan-to-email them to info@american-chiropractic.com . This will help us to have your insurance and new patient information available at your first visit.

Thank you for your time. Please feel free to contact us with any questions. We look forward to seeing you!

Sincerely,

American Chiropractic Clinic Austin

7800 Mo-Pac, Suite 340
Austin, Texas 78759

Phone: (512) 346-5567
www.american-chiropractic.com

PATIENT REGISTRATION – WELCOME!

Lead Dr: M F B

Patient Name _____ Today's Date _____
Address _____ City/St _____ Zip _____
DOB _____ Age _____ SS# _____ Sex: M / F Marital: M / S / D / W
Cell Ph # _____ Home Ph # _____ Work # _____
Spouse's Name _____ # Children ____ Occup _____ Employer _____

Email _____ Please check to receive our clinic schedule/newsletter: **Init:** _____

How were you referred to us? _____ **To Dr:** _____ **Appt Date:** _____

Emergency Contact _____ Ph # _____ Relation _____

Medical Doctor _____ Address _____ Ph # _____

Major Complaint(s) _____

Accident? Auto? Y/N Work? Y/N Other? Y/N Accident date _____ Have you called an Atty? Y/N

If Auto, claim #: _____ Adjuster: _____ Ph # _____ Fax _____

Insurance: Carrier _____ **Ph #** _____

Policy# / Member ID# _____ Group # _____

Policyholder's Name _____ SS# _____ DOB _____

Claims Address _____ City/St _____ Zip _____

For Office Use Only:

In Network? Y / N Plan type: PPO / HSA-HRA / HMO / EPO / PIP / ACN

GW/UHC: Attach Printout from OptumHealth website for ACN info

Policy Effect date _____ Cal Yr/Other _____ Pre-exist clause? Y/N: exp date: _____

Filing Deadline? _____ **Referral Required? Y / N** HSA/HRA Balance: \$ _____

Exam: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

Manip: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

Therapy: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

X-ray: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

Limits: Ofc Visit# ___/used___ Manip# ___/used___ Therapy# ___/used___ 98941=Unit? Y/N

Max \$\$ Cap \$ ___/met___ Units/vst? ___

Acu 97810? Y/N \$ _____ DTS S9090? Y/N \$ _____ Laser S8948? Y/N \$ _____ MT 97140 ? Y/N _____

Max \$\$ OOP _____/met _____ Does OOP incl. ded? _____ Other _____

Rep spoke with _____ **Ref #** _____ **Today's Date** _____ **Your Init:** _____

The above coverage information was obtained from your carrier as a courtesy to you. This is not a guarantee of payment from your insurance carrier. Due to the inaccuracy of insurance companies relaying this information, it is your responsibility to verify the above information and inform us of any conflicts. In the event that we are unable to collect from your carrier in a timely manner, we may send you a bill and ask for your assistance. I _____, agree that I am ultimately responsible for payment of any balances on my account and will help handle any negotiations with my carrier, or any other involved parties, that may be needed to settle my account. I also agree to pay for any treatment considered in excess and/or in exclusion of my carrier coverage.

Patient Signature : _____ **Date:** _____ **Witness:** _____

Prior Treatment for Current Problem

Have you seen anyone else for these symptoms? Y / N Who? _____ Dates: _____

What did they recommend? _____ Medications: _____

Test Results for: X-ray _____ CT/MRI _____

Lab _____ Other _____

Injections: Epidural Facet Other _____ Results: Better No change Worse

Surgery: Year/Type _____ Results: Better No change Worse

Chiropractic: Year/Type _____ Results: Better No change Worse

PT/Other Treatment: Year/Type _____ Results: Better No change Worse

Family Medical History: Anemia Arthritis Diabetes Heart disease High blood pressure

Lupus Cancer Psoriasis Scoliosis Drug allergies Muscle disease Rheumatoid Arthritis

Living Parents? Mother? Y / N: Died at age _____ of _____

Father? Y / N: Died at age _____ of _____

Your Medical History:

- GERD Heart disease Scoliosis Prostate problems
- Anemia Diabetes Hepatitis Lung disease Diverticulitis Lupus Polio
- Arthritis Glaucoma High BP Kidney disease Tuberculosis Migraine headaches
- Asthma Sinus trouble Lupus Thyroid disease Depression Joint replacement
- Cancer AIDS/HIV STD Muscle disease Alcoholism Stroke Seizures
- Ulcers **WOMEN ONLY: LMP:** _____ **Could you be pregnant? Y / N / Uncertain**

List Current medications: _____

Drug Allergies: No Yes: _____

Current Work Status:

Regular Duty Limited/Light Duty: Date began: _____ Off Work: Date began: _____

Lifestyle Habits:

- Tobacco _____ (# cigs/day) Sleep _____ (hrs/day) Current exercise _____ (hrs/week)
- Alcohol _____ (# drinks/day) Caffeine beverages _____ (# drinks/day)

Surgeries/Hospitalizations/Fractures/Dislocations:

_____ Year: _____ | _____ Year: _____ |
 _____ Year: _____ | _____ Year: _____ |

Recent falls or strain/sprains: _____

Have you ever been unconscious? No Yes: When/How? _____

Have you had any of the following recently? (Please check all that may apply):

- | | |
|---|--|
| <p>Constitutional: <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Unexplained weight loss</p> <p>Eyes: <input type="checkbox"/> Abrupt changes of vision</p> <p>Ears, Nose, Throat: <input type="checkbox"/> Abrupt changes in hearing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Sore throat <input type="checkbox"/> Deafness</p> <p>Cardiovascular: <input type="checkbox"/> Chest pain <input type="checkbox"/> Poor circulation</p> <p>Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty breathing</p> <p>Gastrointestinal: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bleeding <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoid</p> <p>Musculoskeletal: <input type="checkbox"/> Pain/swollen joints</p> <p>Skin: <input type="checkbox"/> Rash</p> <p>Neurological: <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Muscle weakness</p> | <p>Endocrine: <input type="checkbox"/> Hot flashes</p> <p>Hematological: <input type="checkbox"/> Bruise easily</p> <p>Immunologic: <input type="checkbox"/> Allergies to pollen, etc.</p> <p>Genitourinary: <input type="checkbox"/> Burning/painful urination <input type="checkbox"/> Loss of bladder/bowel control <input type="checkbox"/> Frequent urination</p> <p>Infection (recent): <input type="checkbox"/> Urinary tract <input type="checkbox"/> Respiratory <input type="checkbox"/> Immune system dysfunction <input type="checkbox"/> Skin <input type="checkbox"/> Other _____</p> <p>Psychosocial: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Fatigue</p> <p>Female: <input type="checkbox"/> Excessive menstrual flow <input type="checkbox"/> Cramps or backache</p> |
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Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is moderate and does not vary much.
- Ⓟ The pain comes and goes and is very severe.
- Ⓡ The pain is very severe and does not vary much.

Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓜ Because of pain my normal sleep is reduced by less than 25%.
- Ⓨ Because of pain my normal sleep is reduced by less than 50%.
- Ⓟ Because of pain my normal sleep is reduced by less than 75%.
- Ⓡ Pain prevents me from sleeping at all.

Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓜ Pain prevents me from sitting more than 1 hour.
- Ⓨ Pain prevents me from sitting more than 1/2 hour.
- Ⓟ Pain prevents me from sitting more than 10 minutes.
- Ⓡ I avoid sitting because it increases pain immediately.

Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓜ I cannot stand for longer than 1 hour without increasing pain.
- Ⓨ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓟ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓡ I avoid standing because it increases pain immediately.

Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓜ I cannot walk more than 1 mile without increasing pain.
- Ⓨ I cannot walk more than 1/2 mile without increasing pain.
- Ⓟ I cannot walk more than 1/4 mile without increasing pain.
- Ⓡ I cannot walk at all without increasing pain.

Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓜ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓨ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓟ Because of the pain I am unable to do some washing and dressing without help.
- Ⓡ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor.
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓟ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓡ I can only lift very light weights.

Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓜ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓨ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓟ Pain restricts all forms of travel except that done while lying down.
- Ⓡ Pain restricts all forms of travel.

Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓜ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓨ Pain has restricted my social life and I do not go out very often.
- Ⓟ Pain has restricted my social life to my home.
- Ⓡ I have hardly any social life because of the pain.

Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓜ My pain seems to be getting better but improvement is slow.
- Ⓨ My pain is neither getting better or worse.
- Ⓟ My pain is gradually worsening.
- Ⓡ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

Name: _____ Date: _____

Date Injured: _____ Time: _____ AM/PM

Describe details of the accident: _____

Have you lost any days of work due to this injury? Y / N Dates: _____

Are you represented by an Attorney? Y / N Name: _____

Address: _____ Phone: _____

You were the: Driver Front Passenger Rear Passenger Pedestrian

in a: Car Truck Other: _____

that: Struck the other(s) Was struck by Car Truck Other: _____

Undetermined

Part of your vehicle hit: Back Front Right side Left side Other: _____

Part of their vehicle hit: Back Front Right side Left side Other: _____

Your vehicle was: Stopped for a traffic signal Stopped to make a turn Parked Moving at time of impact (describe above in Details of Accident section) Other: _____

List any other vehicles or objects involved: _____

You were wearing: Seatbelt Shoulder harness Both None

Airbag(s) opened: Driver Passenger Side None

At the time of impact, where were you looking and how were you positioned? _____

Did your body strike any part of the vehicle? Y / N Describe in detail: _____

Your estimated vehicle speed: _____ Their estimated vehicle speed: _____ Any Witnesses? Y / N

Was a traffic citations issued? Y / N You Driver of your car Driver of the other car

Was a police report written? Y / N Which city? _____

Were you rendered unconscious as a result of the collision? Y / N

Were you checked by EMS? Y / N What did they recommend? _____

Were you seen at an E.R.? Y / N Immediately Later that day Other: _____

Which hospital? _____

How did you get there? EMS Drive Taken by friend/spouse

What did they prescribe or recommend? _____

Have you seen any other doctors or had any treatment? Y / N

What did they prescribe or recommend? _____

American Chiropractic Clinic-Austin 512.346.5567 FAX: 512.231.1087