Welcome Back
205 S Wild Basin Rd, Suite 2A
Austin, TX 78746
p 512.910.2300
f 877.992.4234
welcomebackaustin.medicfusion.com

Patient Profile

Personal Information

Full Name: _____ Jr / Sr
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ H / M / B Alternate Phone: _____ H / M / B

Birth Date: ___/___/___

Social Security Number #: ___-___-___

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown/Unavailable

Prim. Language: ☐ Arabic ☐ Chinese ☐ English ☐ French ☐ German ☐ Greek ☐ Hebrew ☐ Italian
☐ Japanese ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Unknown/Unavailable
☐ Other _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Time Zone: _____

Does your time zone participate in Daylight Savings Time? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do you have any dependents? ☐ Yes ☐ No

Are you a full-time student? ☐ Yes ☐ No

Health Insurance? ☐ Yes ☐ No

Responsible Party: ☐ You ☐ Other (parent, spouse, etc.) _____

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Patient: _____

Chief Complaint Form

Chief Complaint

Case Title: _____

Describe the reason for your visit: _____

_____

_____

When did your symptoms begin? (select one)

☐ Today ☐ This week ☐ Within last 3 months

☐ 3 months to 6 months ☐ 6 months to one year ☐ More than one year

For Women Only: Most recent menstrual cycle: ____/____/____

Are you pregnant? ☐ Yes ☐ No

Which word describes the frequency of your discomfort? (select one)

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare

Which phrases best describe *changes* in your discomfort during the day? (select one or more)

☐ It is worse in the morning ☐ It is worse in the afternoon ☐ It is worse at night

☐ It changes with the weather ☐ It does not change

What helps *relieve* your discomfort? (select one or more)

☐ Ice ☐ Heat ☐ Medication ☐ Other (please describe) _____

What activities are limited by your discomfort? (select one or more)

☐ Bending ☐ Bowel Movements ☐ Coughing ☐ Daily Routine

☐ Driving ☐ Getting Up ☐ Lifting ☐ Lying Down

☐ Pulling ☐ Pushing ☐ Reading ☐ Sitting

☐ Sleeping ☐ Sneezing ☐ Standing ☐ Turning my head

☐ Urination ☐ Walking ☐ Working ☐ Other (please describe) _____

Where applicable, specify the approximate date of your most recent: (month / year)

Physical Exam: ____/____ Dental X-rays: ____/____

Spinal X-ray: ____/____ CT Scan: ____/____

MRI: ____/____ Other Scans or X-rays: ____/____

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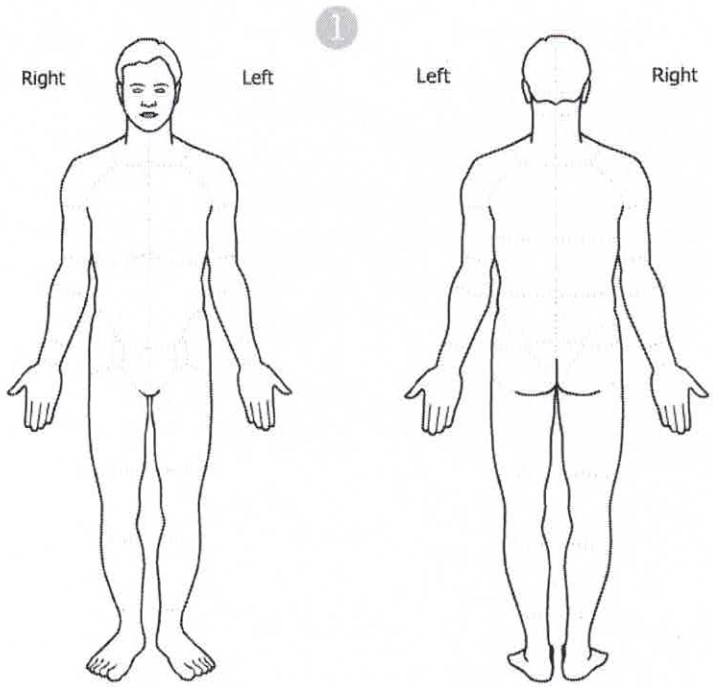
Patient: _____

Patient Symptom Illustrator

Patient Symptom Illustrator



Instructions:

1. Identify your areas of discomfort by marking the affected body parts in the illustration.
2. Indicate the area name along with your specific symptoms associated with each selected area.
3. Rate your discomfort associated with each selected area.

		2									3
		Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness	0 = No Discomfort 10 = Severe Discomfort
Ex.	L (R) Lower Back			X			X			X	0 1 2 3 4 5 6 X 8 9 10
1.	L R										0 1 2 3 4 5 6 7 8 9 10
2.	L R										0 1 2 3 4 5 6 7 8 9 10
3.	L R										0 1 2 3 4 5 6 7 8 9 10
4.	L R										0 1 2 3 4 5 6 7 8 9 10

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Surgical History

Check if you have any implants, screws, plates or other foreign objects in your body. ☐ Yes

☐ Bullet Wound(s) ☐ Infusion Catheter ☐ Ear Implant ☐ Pacemakers ☐ Eye Implant

☐ Brain Plate(s) ☐ Heart Valve(s) ☐ Shrapnel ☐ Other _____

Musculoskeletal Surgeries (Check if you have had any of the following surgeries)

☐ Ankle	Year(s) of surgery: _____		☐ Head	Year(s) of surgery:	_____
☐ Back	Year(s) of surgery: _____		☐ Hip	Year(s) of surgery:	_____
☐ Cosmetic or Augmentation	Year(s) of surgery: _____		☐ Knee	Year(s) of surgery:	_____
☐ Elbow	Year(s) of surgery: _____		☐ Neck	Year(s) of surgery:	_____
☐ Foot	Year(s) of surgery: _____		☐ Shoulder	Year(s) of surgery:	_____
☐ Hand	Year(s) of surgery: _____		☐ Wrist	Year(s) of surgery:	_____
☐ Other	Please describe: _____			Year(s) of surgery:	_____

Organ System Surgeries (Check if you have had any of the following surgeries)

☐ Brain	Year(s) of surgery: _____		☐ Intestine, large	Year(s) of surgery:	_____
☐ Colon	Year(s) of surgery: _____		☐ Liver	Year(s) of surgery:	_____
☐ Esophagus	Year(s) of surgery: _____		☐ Lung	Year(s) of surgery:	_____
☐ Eye	Year(s) of surgery: _____		☐ Mastectomy	Year(s) of surgery:	_____
☐ Heart	Year(s) of surgery: _____		☐ Reproductive Organs	Year(s) of surgery:	_____
☐ Kidney	Year(s) of surgery: _____		☐ Skin	Year(s) of surgery:	_____
☐ Intestine, small	Year(s) of surgery: _____		☐ Throat	Year(s) of surgery:	_____
☐ Other	Please describe: _____			Year(s) of surgery:	_____
☐ Transplant	Please describe: _____			Year(s) of surgery:	_____

WELCOME BACK

Authorizations and Releases

Consent to Professional Treatment. Initial

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of chiropractic is not an exact science and I acknowledge that no guarantees have been made as the result of evaluation and treatment. If the patient is a minor child under the age of 18 at the time of treatment, I hereby stipulate that I am the legal guardian of the child and grant my consent for treatment. I acknowledge that I may refuse treatment at any time.

Consent to perform and Interpret X-Rays Initial

I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of the practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by physicians. At this time, I know of no condition which the taking of x-rays would further complicate.

Patient Health Information and Privacy Policy Initial

This policy outlines the Patient Health Information (PHI) will be used in the office and the patient's rights concerning those records. You must read and consent to this policy prior to receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) visit hhs.gov

The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The Patient agrees to allow this office to submit requested PHI to the payors named by the patient for the purpose of payment. The office will limit the release of PHI to the minimum necessary.

The patient has the right to examine and obtain a copy of the PHI at any time and request corrections.

The Patients written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent.

This office is committed to protecting your PHI and meeting its HIPAA obligations. Staff have been trained in patient record privacy and a privacy official has been designated to enforce those procedures.

Patients have the right to make a formal complaint with our privacy official about any suspected violations.

The office has the right to refuse treatment if the patient does not accept the terms of this policy.

Financial Obligation and Appointment Policy Initial

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical expenses in full due to usual customary rates, benefit exclusions, limits, lack of authorization or medical necessity. I further understand that I am responsible for fees not paid in full, except where my liability is limited by contract or State or Federal Law. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees and any other expenses incurred in the collection of past due accounts.

I hereby accept all responsibility for scheduling and maintaining my appointment schedule with the physician as I understand it is vital to follow care guidelines. I acknowledge that this office charges for missed appointments and same day cancellations. I understand that if there is a case of recurrence and lack of follow through with the care plan, the physician may release me from the office.

Females: Regarding Possibility of Pregnancy Initial

This is to certify that to the best of my knowledge I am NOT pregnant. The doctor and staff have permission to take x-rays. I am aware that taking x-rays, particularly ones involving the pelvis, can be hazardous to a fetus.

Consent to Chiropractic Treatment Initial

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Welcome Back have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do herby consent to treatment by any means, method and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ / / _____

Signature Date