



# MOTION CHIROPRACTIC

8701 W. Parmer Ln. Ste. #2121  
Austin, TX 78729  
Ph: 512.258.8880  
Fax: 512.692.9607

## CONFIDENTIAL PATIENT INFORMATION

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male - Female

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Only disclose if you would like to, or if your insurance goes by this number)

Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Kids names: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

## GENERAL QUESTIONS

**Whom may we thank for referring you?** \_\_\_\_\_

**Or, how did you find us?** \_\_\_\_\_ **Specifically:** \_\_\_\_\_

**Are you in for a:**  **Wellness/Health check-up** or a  **Specific complaint**

Is this condition affecting your everyday life?  **Yes**  **No**

Is it interfering with:  **Work**  **Home life**  **My hobbies**  **My relationships**  **My sleep**  **My happiness**

**My quality of life**  **My Exercise Routine**  **Everything**

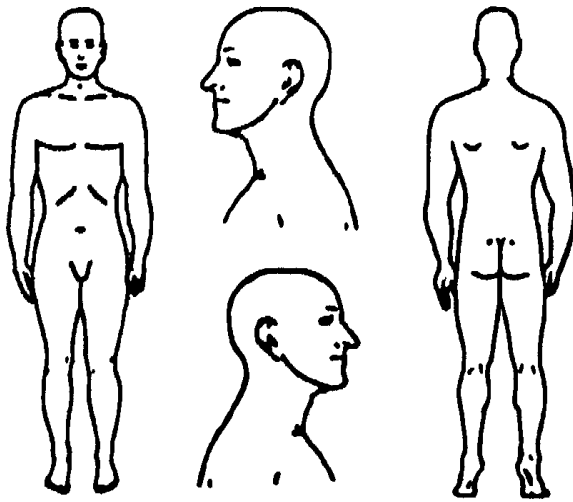
**Have you seen a Chiropractor before?**  **No**  **Yes - Who?** \_\_\_\_\_

When was the last time you were adjusted? \_\_\_\_\_

Did you have a good experience?  **Yes**  **No** Anything you liked or disliked? \_\_\_\_\_

Who is your General Practitioner/ Family Physician? \_\_\_\_\_

**PLEASE MARK OR CIRCLE YOUR AREAS OF PAIN OR DISCOMFORT ON THE DIAGRAM BELOW:**



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level
- Improve my quality of life

**What is your major complaint?** \_\_\_\_\_ **Date problem began** \_\_\_\_\_

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO Are you experiencing this on the: LEFT RIGHT BOTH

Please rate your pain on a scale of 1 to 10 (0= no pain, 10= excruciating pain)  0  1  2  3  4  5  6  7  8  9  10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities)  0  1  2  3  4  5  6  7  8  9  10

How often do you experience your symptoms?

Constantly (76-100% of the day)  Frequently (51-75% of the day)

Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

Describe the nature of your symptoms:  Burning  Dull ache  Numb  Radiating pain  Sharp  Shooting

Stabbing Pain  Tightness  Tingling  Throbbing  Other: \_\_\_\_\_

What activities aggravate your condition (working, exercise, etc)? \_\_\_\_\_

What makes your pain better (ice, heat, massage, etc)? \_\_\_\_\_

**What is your second complaint?** \_\_\_\_\_ **Date problem began** \_\_\_\_\_

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO Are you experiencing this on the: LEFT RIGHT BOTH

Please rate your pain on a scale of 1 to 10 (0= no pain, 10= excruciating pain)  0  1  2  3  4  5  6  7  8  9  10

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What activities aggravate your condition (working, exercise, etc)? \_\_\_\_\_

What makes your pain better (ice, heat, massage, etc)? \_\_\_\_\_

*If you have more than two major complaints, please list them below and rate their severity on the 1-10 scale:*

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### Check those activities below during which you experience difficulty or pain:

- Lying on back     Getting in/out of car     Sleeping     Stooping     Standing for periods over one hour  
 Lying on side with knees bent     Gripping     Pushing     Sitting     Sneezing  
 Turning over in bed     Climbing     Pulling     Bending forward     Coughing  
 Lying flat on stomach     Dressing Self     Reaching     Bending backwards     Straining  
 Sexual Activity     Kneeling     Walking     Other: \_\_\_\_\_

### Headaches/Migraines

Do you have a family history of headaches?     Yes     No

Do you get headaches     Yes     No    Frequency \_\_\_\_\_    Where?     Frontal     Side(temporal)     Back of head (occipital)

Migraines     Yes     No    Frequency \_\_\_\_\_    Where?     Frontal     Side(temporal)     Back of head (occipital)

Do you experience the following along with your headaches/migraines:

Pain/cracking in your jaw?     Yes     No    Abnormal blood pressure?     Yes     No     High     Low

Nausea, Vomiting, or Visual disturbances?     Yes     No    Pain behind eyes?     Yes     No

When was your last eye exam by a doctor?     1-6 months     6-12 months     1-2 years     over 2 years

Results: \_\_\_\_\_

### General Information

What is your typical sleeping position (circle):    BACK    SIDE    STOMACH    ALL OF THEM

How many pillows do you sleep with? \_\_\_\_\_    Are you happy with your pillow?     Yes     No

Do you smoke?     No     Yes

Do you drink alcohol?     No     Yes - how many per day? \_\_\_\_\_

Do you drink caffeine?     No     Yes - how many per day? \_\_\_\_\_

Do you exercise?     No     Yes (what forms and how often?) \_\_\_\_\_

### Additional Information

Have you been X-rayed in the last year? \_\_\_\_\_    When? \_\_\_\_\_    For what purpose? \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Do you have, or have had, any diseases or medical problems not listed     Yes     No

Any additional information you would like the Doctor to know about before beginning care?

## HEALTH HISTORY

List any Allergies:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Animals            | <input type="checkbox"/> Aspirin/Pain Medicine | <input type="checkbox"/> Bee stings     | <input type="checkbox"/> Chocolates/sweets |
| <input type="checkbox"/> Dairy Products     | <input type="checkbox"/> Dust                  | <input type="checkbox"/> Eggs           | <input type="checkbox"/> Latex             |
| <input type="checkbox"/> Molds              | <input type="checkbox"/> Penicillin            | <input type="checkbox"/> Ragweed/Pollen | <input type="checkbox"/> Rubber            |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Shellfish             | <input type="checkbox"/> Soaps          | <input type="checkbox"/> Wheat             |
| <input type="checkbox"/> X-Ray Dye          | <input type="checkbox"/> None known            | <input type="checkbox"/> Sulfa drugs    | <input type="checkbox"/> Other: _____      |

List any **Surgeries** : (includes fractures, spine and neck, wisdom teeth, tubes, C-Sections, Scopes, sutures, etc...)

\_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  
 \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

List **ALL Past Medical History** conditions (if applicable):

- Ankle Pain  Arm Pain  Arthritis  Asthma  Back Pain  Broken Bones  Cancer  Chest Pain  Depression  
 Diabetes  Dizziness  Elbow Pain  Epilepsy  Eye/Vision Problems  Fainting  Fatigue  Foot Pain  
 Genetic Spinal Condition  Hand Pain  Headaches  Hearing Problems  Hepatitis  High Blood Pressure  
 Hip Pain  HIV  Jaw Pain  Joint Stiffness  Knee Pain  Leg Pain  Menstrual Problems  Mid-Back Pain  
 Minor Heart Problem  Multiple Sclerosis  Neck Pain  Neurological Problems  Pacemaker  Parkinson's  
 Polio  Prostate Problems  Shoulder Pain  Significant Weight Change  Spinal Cord Injury  Sprain/Strain  
 Stroke/Heart Attack  Stomach Problems  Tumor  Ulcer/s  Wrist Pain  IBS  Cerebral Palsy  
 Other: \_\_\_\_\_

If female, are you pregnant?  Yes  No  Not Sure If yes, what is your due date: \_\_\_\_\_

List **any and all Medications, followed by Nutritional Supplementation**:

- Anxiety  Muscle Relaxors  Pain Killers  Insulin  Birth control  Cardiovascular  Allergy  Seizure  
 Others: \_\_\_\_\_ Reason \_\_\_\_\_  
 Others: \_\_\_\_\_ Reason \_\_\_\_\_  
 Others: \_\_\_\_\_ Reason \_\_\_\_\_

If Nutritional and/or and Supplements, please list below:

- Others: \_\_\_\_\_ Reason \_\_\_\_\_  
 Others: \_\_\_\_\_ Reason \_\_\_\_\_  
 Others: \_\_\_\_\_ Reason \_\_\_\_\_

List your **Family History**:

- Arthritis  Asthma  Back Pain  Cancer  Depression  Diabetes  Epilepsy  Genetic Spinal Condition  
 High Blood Pressure  Heart Problems  Multiple Sclerosis  Neurological Problems  Parkinson's  Polio  
 Prostate Problems  Stroke/Heart Attack  Other condition: \_\_\_\_\_

Who suffered from these (check):  Mother  Father  Grandparents (Maternal)  Grandparents (Paternal)  Sibling  
 Son  Daughter  Aunt  Uncle

Have you had any **auto accidents or other accidents in the past?** (falls, injuries, surgeries)  No  Yes

Year: \_\_\_\_\_ Describe: \_\_\_\_\_  
Year: \_\_\_\_\_ Describe: \_\_\_\_\_  
Year: \_\_\_\_\_ Describe: \_\_\_\_\_

**If a recent auto accident case**, when was the date of the incident? \_\_\_\_\_

Was anybody else in the car with you? \_\_\_\_\_

Were you wearing a seatbelt? \_\_\_\_\_

Describe the accident briefly: \_\_\_\_\_  
\_\_\_\_\_

# Informed Consent

I certify that the above information is correct to the best of my knowledge. I will not hold my Doctor or any staff member of Motion Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s), and physical therapies on me as deemed appropriate (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future render treatment to me while employed by, working for, or associated with, or serving as back-up for the Doctor of Chiropractic named below.

Name of Doctor(s) treating this patient:

Erica Manger, D.C.

Lorenz Hamburger, D. C.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill. I understand that, as with any health care procedure, there are certain complications which may arise during a Chiropractic adjustment or Acupuncture Treatments. It is necessary to inform the patient of such risks prior to initiating care. While chiropractic and acupuncture treatments are remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Specific risks and possibilities associated with **Chiropractic Care:**

*Soreness*- Chiropractic adjustments or any type of physical therapy procedures are sometimes accompanied with post treatment soreness. This is a normal and accepted response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your Doctor if you experience soreness or discomfort.

*Soft Tissue Injury*- Occasionally chiropractic adjustments may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

*Rib injury*- Manual adjustments to the thoracic spine or mid back, in rare cases, may cause rib injure or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

*Stroke*- Stroke is one of the most serious complications of chiropractic treatment. Some types of manipulation to the upper cervical area have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise good judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

Chiropractic care is a system of health care delivery and therefore, as with any health delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. Our goal is to provide you with the very best care and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risks and possibilities associated with **Acupuncture Treatments:**

*Bleeding* - There is a risk of minor bleeding associated with acupuncture. People with bleeding disorders and those taking anticoagulants are advised not to use acupuncture because of this risk.

*Soreness or pain* - This may result from improper needle placement, movement of the patient or a defect in the needle.

*Organ punctures* - If delivered improperly, acupuncture can result in puncture of an organ.

*Infection* - Patients may develop an infection as the result of inadequately sterilized needles. (We use only brand new/packageged needles).

*Transmission of an infectious disease* - As with all procedures involving the use of needles, acupuncture carries a risk of transmitting an infectious disease.

*Broken needles* - There is a small risk that an acupuncture needle may break, leaving a piece of metal imbedded in the skin.

*Forgotten needles*. -There is a slight risk that a practitioner may accidentally leave an acupuncture needle in the skin at the end of a treatment session.

I have read \_\_\_\_ or have read to me \_\_\_\_ the above explanation of the chiropractic adjustment, acupuncture treatment, and related treatments. By signing below, I state that I have weighed any risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo Chiropractic and/or Acupuncture treatments if my case is accepted. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Massage:**

I hereby request and consent to the performance of stretching and or massage which are being performed by the licensed massage therapists employed by Motion Chiropractic. I understand that there are specific risks associated with massage and associated therapies, such as bruising, nausea, increased inflammation, flu-like symptoms, rashes/allergic reactions and muscle soreness. I understand that any soreness after massage is a normal side effect. If I experience any pain or discomfort during the session, I will immediately communicate that to the therapist so the massage can be adjusted.

Printed name of patient \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby consent to any/all **X-Rays** taken on this visit. Initial: \_\_\_\_\_

If **female**, I hereby acknowledge to the best of my knowledge that I am NOT pregnant. Initial: \_\_\_\_\_

Last Menstrual cycle (Date): \_\_\_\_\_ Initial: \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Appointment Policy

Thank you for choosing our office! It is our intention to provide you with the finest Chiropractic and wellness services, and we thought you would appreciate some clear guidelines for maximizing your experience with us. Office visits are scheduled according to severity of your condition and the program of Chiropractic care the doctor feels is best for you. Because your condition requires numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask that you assume the responsibility of strict adherence of the appointment program as it is designed for optimal results.

In addition to your regular scheduled appointments, you will also have periodic reexaminations to determine progress and to make any appointment alterations to your program of care. Regardless of how many appointments are scheduled per week, please note it is the frequency of visits that counts, not the days on which you receive the service. If, for any reason you are unable to keep an appointment, we require that you call immediately to reschedule that visit. It is your responsibility to make up missed appointment within 7 days of any cancellation. Also, this office reserves the right to charge for missed appointments or and those cancelled without at least 12 hours notice.

When entering the office on any given visit, please go directly to the front desk and "sign in". We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

## Massage Policy

If you are scheduling a massage for yourself or a family member, we require you schedule at least 6 hours in advance. If you for some reason are unable to make your scheduled appointment time, we ask that you call ahead at least 2 hours prior to that appointment, or you will be charged for the massage. If you are late for your massage, you will still owe for the entire time, but will only receive the portion of time left in your massage, as there may be a massage before and after yours.

## 30 Minutes to Wellness Workshop

The purpose of requiring all new patients to attend our 30 minutes to Wellness Workshop is to enlighten you about your body, especially the spine and nerve system. Since Chiropractic is not like the practice of medicine and is probably new to you, it is essential for you to understand how to help us help you get well faster. We have found that patients who attend our short workshop respond better, because they understand the cause of their problem and what we are attempting to do to correct it. Proper health care is a two-way street, meaning that both the doctor and the patient have various responsibilities to uphold, if you want to reach maximum benefits in the minimum amount of time. Natural healing requires our joint cooperation. That's why your attendance at this workshop is strongly encouraged, as it is part of your program of care. Further, we invite you to bring your spouse or another family member, so they can understand too, and learn to assist you in your quest to regain your health. Friends, co-workers or relatives may also attend, as it is a terrific way for them to find out the value of Chiropractic care and see if it applies to their lifestyles. Just ask at the Front Desk to reserve a place for your guests. Light refreshments will be served at these events!

I hereby acknowledge and have read the above appointment policy, massage policy and workshop requirement.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_