Essential Chiropractic and Wellness
802 W. St. Elmo
Austin, TX 78745

Dr. Renee Hilmer, D.C., F.I.A.M.A.
(512) 443-9200
dr@expectachange.com

New Patient Forms: Health Record

Today's Date:_____/_____/_____

How did you hear about us?

- ☐ Family
- ☐ Co-worker
- ☐ Search Engine
- ☐ Expectachange.com
- ☐ Friends
- ☐ Close to home
- ☐ Drove By
- ☐ Dr._____

Personal Information

First: _____ **Middle**: _____ **Last**: _____

Birth Date: _____ /_____ /_____ **Age**: _____ **Sex:** *(circle one)*: Male / Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____ **Apt**: _____

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

Home Phone: (_____) _____ - _____ **Work Phone**: (_____) _____ - _____ ext. _____

Cell Phone: (_____) _____ - _____ **Fax**: (_____) _____ - _____ ext. _____

Email Address: _____ **Spouses Name**: _____

Children: *(name/age)*: _____

Emergency Contact

First: _____ **Last**: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Home Phone: (_____) _____ - _____ **Work Phone**: (_____) _____ - _____ ext. _____

Employment Information

Business Name: _____

Work Phone: (_____) _____ - _____ ext. _____

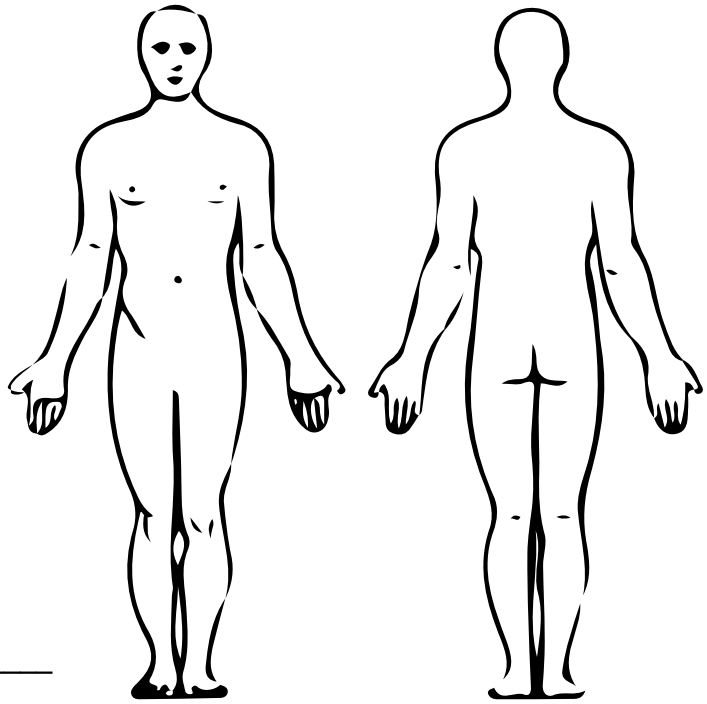
Occupation/Job Title: _____ **Job Description**: _____

Current Health Condition

Tell us why you are here today: _____

_____

Please label on the diagram areas of discomfort.



Use the key below to indicate TYPE and LOCATION of your sensations right now.

KEY: A= Ache **B**=Burning **N**= Numbness
P= Pins & Needles **S**= Stabbing

When did this condition begin? _____ /_____ /_____

Has this ever occurred before? ☐ Yes ☐ No

If yes, when? _____

Is the condition: ☐ Auto related ☐ Job related

☐ Home injury ☐ Slip or fall ☐ Lifting ☐ Slept wrong

☐ Unknown cause Other Explain: _____

_____

Date of accident: _____ /_____ /_____ **Time of accident:** _____am/pm

Condition/Pain STARTED on what date? _____

Do you SUFFER with ANY OTHER condition than which you are now consulting us? _____

_____

Review of Systems

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ chills ☐ fatigue ☐ night sweats ☐ weight loss ☐ daytime drowsiness ☐ weight gain ☐ fever

Eyes/Vision

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ Blindness ☐ Change in vision ☐ Field Cuts ☐ Photophobia ☐ Blurred Vision ☐ Itching

☐ Double vision ☐ Glaucoma ☐ Tearing ☐ Cataracts ☐ Eye Pain ☐ Glasses/contacts

Respiration:

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ asthma ☐ coughing up blood ☐ sputum production ☐ cough ☐ shortness of breath ☐ wheezing

Ears/Nose/Throat

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ Bleeding	☐ Ear drainage	☐ Hearing loss	☐ Nose bleeds	☐ Discharge
☐ Dentures	☐ Ear pain	☐ Post nasal drip	☐ Ringing in ears	☐ Headaches
☐ Fainting	☐ Hoarseness	☐ Runny nose	☐ TMJ problems	
☐ Sore throat	☐ Loss of sense of smell	☐ Sinus infection	☐ Dizziness	
☐ Nasal congestion	☐ Snoring	☐ History of head injury	☐ Difficulty swallowing	

Cardiovascular

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ angina (chest pain)	☐ high blood pressure	☐ shortness of breath	☐ chest pain	☐ low blood pressure
☐ swelling of legs	☐ claudication (leg pain)	☐ ulcers	☐ heart murmur	☐ palpitations
☐ varicose veins	☐ heart problems	☐ waking at night w/shortness of breath	☐ difficulty breathing lying down	

Gastrointestinal

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ abdominal pain	☐ diarrhea	☐ indigestion	☐ abnormal stool caliber	☐ vomiting blood	☐ belching	
☐ vomiting	☐ difficulty swallowing	☐ jaundice	☐ difficulty swallowing	☐ abnormal stool color	☐ rectal bleeding	
☐ black tarry stools	☐ heartburn	☐ nausea	☐ constipation	☐ hemorrhoids	☐ abnormal stool consistency	

Female

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ birth control	☐ cramps	☐ irregular menstruation	☐ vaginal bleeding	☐ breasts lumps/pain	
☐ frequent urination	☐ pregnancy	☐ vaginal discharge	☐ burning urination	☐ hormone therapy	☐ urine retention

Male

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ burning urination	☐ frequent urination	☐ prostate problems	☐ erectile dysfunction	☐ hesitancy/dribbling	☐ urine retention

Endocrine

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ cold intolerance	☐ excessive hunger	☐ goiter	☐ unusual hair growth	☐ abnormal frequency of urination	
☐ diabetes	☐ excessive thirst	☐ hair loss	☐ voice change	☐ excessive appetite	☐ heat intolerance

Skin

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ Changes in nail texture ☐ Hair Loss ☐ Itching ☐ Skin Lesion/Ulcer ☐ Changes in skin color

☐ Hives ☐ Paresthesias ☐ Varicosities ☐ Hair growth ☐ Skin disorders

☐ Rash

Nervous System

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ dizziness ☐ limb weakness ☐ numbness ☐ slurred speech ☐ tremor ☐ facial weakness

☐ loss of consciousness ☐ seizures ☐ stress ☐ unsteadiness of gait/loss of balance

☐ headache ☐ loss of memory ☐ sleep disturbance ☐ strokes

Psychological

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ Anhedonia ☐ Behavior change ☐ Convulsions ☐ Memory loss ☐ Confusion ☐ Insomnia

☐ Bi-polar Disorder ☐ Mood change ☐ Loss/change of appetite ☐ Anxiety ☐ Depression

Allergy

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ anaphalaxis ☐ itching ☐ chronic nasal congestion ☐ sneezing

☐ acute nasal congestion ☐ rash ☐ food intolerance

Hematologic

☐ I **DENY** having or have had any of the symptoms or problems listed below.

☐ anemia ☐ blood clotting ☐ bruises easily ☐ lymph node swelling ☐ bleeding

☐ blood transfusion ☐ fatigue

Past Health History

Fill out carefully as these problems can affect your overall course of care.

Previous Care for this same condition:

☐ I have not previously seen a doctor for this condition.

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No If yes, who? _____

Type of Treatment: _____

Were you satisfied with the results of your treatment? ☐ Yes ☐ No Explain _____

_____

Previous Chiropractic Care:

☐ I have not previously seen a chiropractor. Or fill out the info below.

Doctor's name: _____ **Location**: _____ **Date of last visit**:_____

_____

Were you satisfied with your care? ☐ Yes ☐ No Why? _____

Do you have any of the following? ☐ Heel lifts ☐ Innersoles ☐ Arch Supports ☐ Orthotics ☐ Other _____

For how long? _____ **Were they purchased by a doctor?** ☐ Yes ☐ No

Current Medication(s) List ANY/ALL medications you are CURRENTLY taking. Be specific.

Medication	Dosage	For what condition?	How long?

Current Vitamins, herbs, etc. List ANY/ALL non-prescription items you are CURRENTLY taking. Be specific.

	Dosage	For what condition?	How long?

Childhood Illness(es) LIST all health conditions. CIRCLE all CURRENT conditions.

☐ ADD	☐ Depression	☐ Seizure Disorder	☐ Cerebral palsy	☐ Measles
☐ Atopic Dermatitis	☐ Headaches	☐ Sickle Cell Anemia	☐ Diabetes	☐ Mumps
☐ Allergies/Hay-fever	☐ Hepatitis	☐ Anemia	☐ Ear Infections	☐ Psoriasis
☐ Chicken Pox	☐ HIV	☐ Asthma	☐ Fetal Drug Exposure	☐ Rash
☐ Crohns/Colitis	☐ Scoliosis	☐ Bed wetting	☐ Food Allergies	☐ Spina Bifida

☐ Other: _____

Do you believe the adult illnesses listed below are contributory to your CURRENT condition?: ☐ Yes ☐ No

Adult Illness(es) LIST all health conditions. CIRCLE all CURRENT conditions.

- [ ] ADD
- [ ] Alzheimer's
- [ ] Anemia
- [ ] Arthritis
- [ ] Asthma
- [ ] Cancer
- [ ] Cerebral Palsy
- [ ] Chicken Pox
- [ ] Crohns Colitis
- [ ] CRPS (RSD)
- [ ] CVA (Stroke)
- [ ] Cystic Kidney Disease
- [ ] Depression
- [ ] Diabetes (insulin dep)
- [ ] Diabetes (non insulin)
- [ ] Eczema
- [ ] Emphysema
- [ ] Eye problems
- [ ] Fibromyalgia
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] HIV
- [ ] Hypertension
- [ ] Flu
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Lupus (discoid)
- [ ] Lupus (systematic)
- [ ] Parkinson's Disease
- [ ] Unspecified Pleural Effusion
- [ ] Pneumonia
- [ ] Psoriasis
- [ ] Psychiatric Problem
- [ ] Scoliosis
- [ ] Seizures
- [ ] Shingles
- [ ] Past history of similar problems
- [ ] STD's (unspecified)
- [ ] Suicide Attempt(s)
- [ ] Thyroid problems
- [ ] Vertigo
- [ ] Other: _____

Surgery (ies)

LIST all surgical procedures. Write the DATE of the procedure immediately afterward.

- [ ] Angioplasty
- [ ] Appendectomy
- [ ] Caesarian Section
- [ ] Cardic Catheterization
- [ ] Carpel Tunnel repair
- [ ] Spinal Fusion
- [ ] Coronary Artery Bypass
- [ ] Cosmetic
- [ ] D & C
- [ ] Dental Surgery
- [ ] Gall Bladder
- [ ] Tonsillectomy
- [ ] Hemorrhoidectomy
- [ ] Hernia Repair
- [ ] Hysterectomy
- [ ] Joint Replacement
- [ ] Joint reconstruction
- [ ] Other: _____
- [ ] Knee Repair
- [ ] Laminectomy
- [ ] Mastectomy
- [ ] Pacemaker insertion
- [ ] Rotator Cuff

Females ONLY: Ob/Gyn

Mark all that apply.

If you have been pregnant in the past, please fill out the appropriate information below.

Number of complicated pregnancies: _____

Number of uncomplicated pregnancies: _____

Number of C-Sections: _____

Number of vaginal deliveries: _____

Number of miscarriages: _____

Number of terminated pregnancies: _____

I am [ ] currently or [ ] NOT currently pregnant.

Menstrual History

I [ ] currently have or [ ] currently do not have menses.

My menses are regular. [ ] Yes [ ] No

Age of first menses: _____

Age when meta-phase started: _____

Date of last mensus: _____

Injury (ies)

Mark or list ALL injuries. Write the DATE of the injury immediately afterward.

- ☐ Back injury
- ☐ Broken bones
- ☐ Disability(ies)
- ☐ Fall (severe)
- ☐ Fracture
- ☐ Head injury (loss of consciousness)
- ☐ Head injury (no loss of consciousness)
- ☐ Industrial accident
- ☐ Joint Injury
- ☐ Laceration (severe)
- ☐ Motor vehicle accident
- ☐ Soft tissue injury (mild)
- ☐ Soft tissue injury (mod)
- ☐ Soft tissue injury (severe)
- ☐ Other:
- ☐ _____

Immunization(s)

Mark or list ALL injuries. Write the DATE of the injury underneath the term.

- ☐ Adenovirus
- ☐ Anthrax
- ☐ Botulism
- ☐ Diphtheria
- ☐ DTaP
- ☐ Flu
- ☐ Haemophilus
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Influenza
- ☐ IPV (Polio)
- ☐ Japanese Encephalitis
- ☐ Lyme Disease
- ☐ Measles
- ☐ Meningococcal
- ☐ MMR
- ☐ Mumps
- ☐ Pertussis
- ☐ Pneumococcal
- ☐ Pneumovax
- ☐ PPD (mantoux test- TB)
- ☐ Rabies
- ☐ Rotavirus
- ☐ Rubella
- ☐ Smallpox
- ☐ Tetanus
- ☐ Tuberculosis
- ☐ Tularemia
- ☐ Typhoid
- ☐ Varivax (Chicken Pox)
- ☐ Whooping Cough
- ☐ Yellow Fever
- ☐ Other:

_____

_____

Non- Drug Allergies:

Mark all that apply.

- ☐ Adhesive type
- ☐ Animals
- ☐ Bee sting
- ☐ Chocolate
- ☐ Dairy
- ☐ Eggs
- ☐ Feathers
- ☐ Food coloring
- ☐ Latex
- ☐ Mold
- ☐ Newsprint
- ☐ Nuts
- ☐ Peanuts
- ☐ Perfumes
- ☐ Pollen
- ☐ Shellfish
- ☐ Smoke
- ☐ Soap
- ☐ Soy
- ☐ Wheat
- ☐ Other: _____

Label the NUMBER (#) of the type of reaction you have to each allergy immediately AFTER the allergy above.

1. Angioedema
2. Anaphylaxis
3. GI disturbance
4. Headache
5. Joint pain
6. Rash
7. Shortness of breath
8. Unspecified reaction

Family History:

Mark all that apply below. List any specific conditions past or present after "has/had."

General family:	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Father:	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Mother	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Paternal Grandfather:	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Paternal Grandmother:	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Maternal Grandfather:	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Maternal Grandmother:	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Son(s)	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Daughter(s):	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Brother(s):	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____
Sisters(s):	☐ Alive	☐ Deceased	☐ Normally Developed	☐ No Significant Disease	☐ has/had: _____

Social History:

Mark all that apply below.

Alcohol:

☐ Do not drink

☐ social consumption only

☐ Drink the following regularly: ☐ Beer ☐ Liquor ☐ Wine

Quantity of _____oz/glasses per ☐ Day ☐ Week ☐ Month

My dietary intake consists of the following: (mark all that apply):

☐ High Fat ☐ High Protein ☐ Low Calorie ☐ Low Fiber ☐ Low Sugar

☐ High Fiber ☐ High Sodium ☐ Low Carbohydrate ☐ Low Sodium

Mark the highest level of Education completed:

☐ Preschool	☐ High School	☐ College	☐ Doctorate
☐ Elementary school	☐ High School Graduate	☐ College Graduate	☐ Graduate School
☐ Middle school	☐ GED	☐ Associates Degree	☐ Graduate Degree
☐ Vocational school	☐ High School (Incomplete)	☐ Bachelors Degree	☐ Other: _____

Substance:

☐ Never use illegal drugs ☐ Has not used drugs since:_____

☐ Never used IV drugs ☐ Used illegal drugs since: _____(how long?)

Tobacco:

☐ Do not smoke

☐ Live with a smoker

☐ Quit smoking

☐ Do not smoke cigars, cigarettes or pipe

☐ Smoke: # _____ per ☐ Day ☐ Week ☐ Month

☐ Chew: # _____ cans per ☐ Day ☐ Week ☐ Month

Current Complaints: List from most to least severe. & **rate your pain intensity** from 0-10 (10 being the worst)

Pain rating

#1. _____ ☐

#2. _____ ☐

#3. _____ ☐

#4. _____ ☐

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Printed Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

In the course of your care as a patient at Essential Chiropractic and Wellness, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, inform you of health related meetings, workshops or products or and other information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care services to you in an emergency.
*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
*If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

By signing below, I acknowledge that I have read the above information.

Patient Signature: _____ Date: ____/____/____

*Please note changes to HIPAA laws that went into effect 9/1/13. A copy of these Federal Privacy Laws are available at your request.

We will not release your personal Health care information without prior written consent.

Informed Consent of professional Services and Release of Information

I hereby authorize and release the doctor and whomever she may designate as her assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic care or any clinic services that she deems necessary in my case; and I further authorize her to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer to the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, companies, insurance companies,workers compensation carriers, welfare funds or the patient's employer.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health you must also be aware of the existence of inherent risks and limitations to chiropractic care. Every type of treatment (medical, chiropractic, or otherwise) carries some form of potential risk associated with it. Risks associated with some forms of chiropractic care include muscular sprain/strain, neurological deficit, osseous fracture and vertebral artery dissection (stroke). While the incidence of injury from chiropractic care is extremely low, and only seldom are the risks great enough to contraindicate care, these facts should be considered in making the decision to receive chiropractic care.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care; including the risk that care I receive in this office may not accomplish the desired clinical objective. I have been advised of reasonable alternative treatments, including known risks, consequences, and probable effectiveness of each, and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been provided to me concerning the results of the care I will receive.

I have read the above paragraphs. I understand the information provided has been explained and any questions I have asked have been explained to my satisfaction.

I knowingly authorize Essential Chiropractic and Wellness to proceed with chiropractic care and treatment.

Patient Signature: _____ Date: ____/____/____