AUSTIN FUNCTIONAL WELLNESS

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Welcome to Austin Functional Wellness! We are dedicated to partnering with you to find the best course of treatment to address your health concerns, from acute pain to chronic conditions. We utilize a number of tools and approaches, as well as collaborate with other healthcare professionals, to provide holistic care and a strong foundation of health for our patients.

NEW PATIENT INTAKE FORM

Date: _____ Marital Status: ☐ Married/Partners ☐ Single ☐ Widowed ☐ Divorced ☐ Other

Patient Name: _____ Email: _____

Address: _____ Cell phone: _____

City: _____ State: _____ Zip: _____ Home phone: _____

Age: _____ Birthdate: _____ SS#: _____ Work phone: _____

Gender: _____ Weight: _____ Height: _____

Spouse/Partner Name: _____ # of children and ages: _____

Occupation: _____ Employer: _____

Employer Address: _____

Referred by: _____ Relationship: _____

Accompanied to office by: _____ Relationship: _____

Reason for Visit

My Top 3 Health Concerns and Symptoms Are:

#1
#2
#3

Chiropractic/Pain Management

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If so, whom? _____

For what condition? _____

What is your current primary problem with pain? _____

The primary reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic

When did the condition begin? ___/___/___ The onset was: ☐ Gradual ☐ Sudden

What causes your pain to **WORSEN**? _____

What gives you the **GREATEST RELIEF/CONTROL** of pain? _____

How long can you: Sit _____ Stand _____ Drive _____ Walk _____

Do you have difficulty with: ☐ Dressing ☐ Personal Hygiene ☐ Housework ☐ Yard work ☐ Preparing meals

Any other activities of daily living that you are having difficulty with due to your present complaint(s)?

Please describe the pain and its location: _____

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Is there radiation or referral of pain to other areas of your body? ☐ Yes ☐ No Where? _____

On a scale from 0-10, please rate your pain (0=no pain 10=extreme pain): _____

Dr.'s Notes: _____

Previous Injuries: ☐ Auto ☐ Workers Comp ☐ Other: _____ Date(s): _____

Current and Past Symptoms and Conditions

Please mark an "X" for each one which you are or have experienced:

MUSCULAR/SKELETAL:	**Current**	**Past**
Neck pain	☐	☐
Low back pain	☐	☐
Joint pain or swelling	☐	☐
Loss/change in sensation of hands/feet	☐	☐
Artificial bones/joints	☐	☐
Fractures	☐	☐
Osteoarthritis	☐	☐
Auto or bicycle accident	☐	☐
Osteopenia/Osteoporosis	☐	☐
Hernia	☐	☐
Leg cramps	☐	☐
GASTROINTESTINAL:	**Current**	**Past**
Bloating	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Cramps	☐	☐
Heartburn	☐	☐
Difficulty swallowing	☐	☐
Food allergies or sensitivities	☐	☐
Loss of appetite	☐	☐
Excessive food cravings/appetite	☐	☐
Blood in stool	☐	☐
Nausea or vomiting	☐	☐
Ulcers or Colitis	☐	☐
Irritable Bowel Syndrome (IBS)	☐	☐
Gallbladder/gall stones	☐	☐
High Cholesterol	☐	☐
High Triglycerides	☐	☐

BRAIN/NEUROLOGICAL:	**Current**	**Past**
Difficulty concentrating	☐	☐
Fogginess	☐	☐
Difficulty staying focused	☐	☐
Poor balance	☐	☐
Loss of smell	☐	☐
Speech difficulty	☐	☐
Memory problems (short- or long-term?)	☐	☐
Seizures	☐	☐
Fainting	☐	☐
Headaches/Migraines	☐	☐
Epilepsy	☐	☐
Concussion	☐	☐
Depression	☐	☐
Nervousness	☐	☐
Anxiety	☐	☐
Irritable/moody	☐	☐
Crying spells	☐	☐
Insomnia (falling or staying asleep)	☐	☐
Sleep apnea	☐	☐
Restless leg	☐	☐
VESTIBULAR:	**Current**	**Past**
Dizziness	☐	☐
Vertigo/spinning	☐	☐
Car or motion sickness	☐	☐
Loss of consciousness	☐	☐

Dr's Notes: _____

AUDITORY/VISUAL:	Current	Past
Ringing in ears	☐	☐
Earaches	☐	☐
Hearing loss	☐	☐
Light bothers eyes	☐	☐
Blurred vision	☐	☐
Glaucoma	☐	☐
Spots in front of eyes	☐	☐
Frequent eye infections	☐	☐
Dry/watery eyes	☐	☐

ENDOCRINE:	Current	Past
Hypothyroid	☐	☐
Hyperthyroid	☐	☐
Diabetes	☐	☐
Fatigue	☐	☐
Recent weight gain	☐	☐
Recent weight loss	☐	☐
Difficulty losing or maintaining weight	☐	☐
Blood in urine	☐	☐
Frequent or burning urination	☐	☐
Abnormal menstruation	☐	☐
Hot flashes	☐	☐
Excessive sweating	☐	☐
Reaction to hot or cold	☐	☐
Sexual dysfunction	☐	☐

INFLAMMATION/IMMUNITY:	Current	Past
Fever	☐	☐
Chills	☐	☐
Hoarseness	☐	☐
Recurring sore throat or head cold	☐	☐
Sinus problems	☐	☐
Allergies (type:_____)	☐	☐
Rheumatoid arthritis	☐	☐
Gout (right or left side?)	☐	☐
Rheumatic fever	☐	☐
Cancer: type _____	☐	☐
Chemotherapy	☐	☐
Venereal disease	☐	☐
HIV+/AIDS	☐	☐

CARDIOPULMONARY:	Current	Past
Heart palpitations/fluttering	☐	☐
Chest pain	☐	☐
Cold hands or feet	☐	☐
Varicose veins	☐	☐
Heart attack	☐	☐
Stroke	☐	☐
High or low blood pressure	☐	☐
Heart murmur	☐	☐
Congenital heart defect	☐	☐
Mitral valve prolapse	☐	☐
Artificial valve	☐	☐
Heart surgery/Pacemaker	☐	☐
Asthma	☐	☐
Cough	☐	☐
Difficulty breathing/shortness of breath	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐

SKIN/INTEGUMENTARY:	Current	Past
Dry skin or hair	☐	☐
Skin rashes	☐	☐
Eczema/**Psoriasis**	☐	☐
Shingles	☐	☐
Growing moles	☐	☐
Skin cancer	☐	☐

OTHER:	Current	Past
Excessive alcohol or drug use	☐	☐
Recent dental work	☐	☐

Dr's Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

Past Surgeries or Hospitalization

List all times and reasons you have had surgery, been hospitalized or severely injured:

Date	Procedure (what & why) and if outpatient or inpatient	Doctor & Medical Facility

Family Health History

Mark an "X" for all applicable conditions and circle type:

	Mother	Father	Sister	Brother	Grandparent
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease (type: stroke, heart attack, other: _____)	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Asthma or Emphysema	☐	☐	☐	☐	☐
Cancer (type:_____)	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Seizures or Epilepsy	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Birthmarks	☐	☐	☐	☐	☐
Bleeding or Blood Disorder (leukemia, other: _____)	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Mental Illness (depression, anxiety, bipolar, schizophrenia)	☐	☐	☐	☐	☐
Addiction (alcohol, drug, prescription medication)	☐	☐	☐	☐	☐
Parents living/in good health? ☐ Yes ☐ No If deceased:	☐	☐	Age:_____	Cause:_____	

All Current Medications and Supplements

Please list all medications, vitamins or supplements you currently take (including those without a prescription):

Name	Dosage	Times per Day	Reason

Taking hormones (i.e., estrogen, progesterone, DHEA, testosterone, growth hormone, steroids)? Please list below including dosage and times per day:

Lifestyle Habits & Activity

Do you or have you ever used tobacco? ☐Yes ☐No Type: ☐Cigarettes ☐Cigar ☐Pipe ☐Chew
Quantity per day: _____ Duration of use: _____ ☐Quit _____ years/months ago
Have you been exposed to second hand smoke? ☐Yes ☐No When? _____

Do you or have you ever used alcohol? ☐No ☐Socially ☐Daily ☐Rarely How many years?_____
Type of alcohol: ☐Beer ☐Wine ☐Hard liquor Quantity: _____ drinks per Day/Week/Month
Do you or have you ever used cannabis/marijuana? ☐Yes ☐No
Quantity per day: _____ Duration of use: _____ ☐Quit _____ years/months ago

What type of caffeinated beverages do you drink? ☐coffee ☐tea ☐cola/soda ☐energy drink ☐chocolate
____cups/day
How much plain water do you drink per day? _____ cups/day ☐filtered ☐bottled ☐tap ☐well

Do you eat 3 meals a day? ☐Yes ☐No _____ % of meals at restaurant or fast food
Do you eat lunch at your work desk? ☐Yes ☐No Do you eat dinner in front of the TV? ☐Yes ☐No
Do you believe you eat a healthy, balanced diet? ☐Yes ☐No If not, why? _____
Would you like a free 15 minute diet assessment? ☐Yes ☐No

What exercise/physical activity do you do regularly now? ☐jog/run ☐swim ☐weights ☐walk ☐bike
☐hike ☐dance ☐aerobics ☐garden ☐ski/snowboard ☐yoga ☐martial arts ☐x-country ☐racquet sport
☐other: _____
Frequency: ☐daily ☐weekly ☐monthly

How many hours of sleep do you get (uninterrupted): ____ Time you go to sleep (routinely): _____
Do you have trouble falling asleep? ☐Yes ☐No Do you have trouble waking up in the morning? ☐Yes ☐No
Do you snore? ☐Yes ☐No Does your significant other snore? ☐Yes ☐No

Emergency Contacts

Name of Emergency Contact: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ ☐Cell: _____
Medical Doctor: _____ Phone:_____

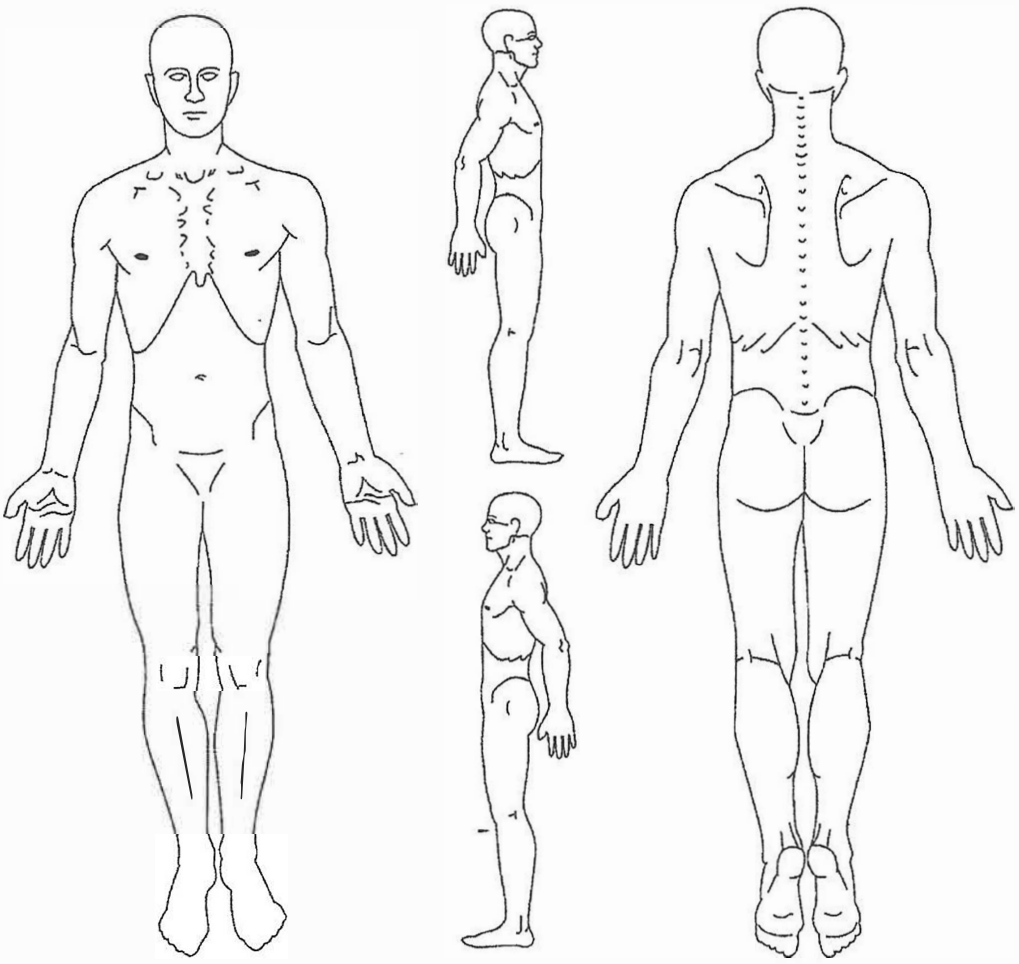
By signing below, you understand and agree to the following:

- The best wellness services are based on a friendly, mutual understanding between provider and patient. We invite you to discuss with us any questions about our services.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You are responsible for your account balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I authorize the provider and/or managed care organization, to release any information required to process insurance claims.
- I guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical or health status.

Patient Signature: _____ **Date:** _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain ——— Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain ——— Unbearable Pain

Rate your **average** pain in the past week:

No Pain ——— Unbearable Pain

Rate your **worst** pain in the past week:

No Pain ——— Unbearable Pain

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Patient Name: _____

Patient Account: _____

Claim Number: _____