

AUSTIN LONGEVITY CENTER

Phone: (512) 448-0900

**NEW PATIENT HEALTH HISTORY**

Thank you for your interest in chiropractic care at Austin Longevity Center. Please complete this health history.  
All the information obtained in this history will help us assess you today and assist you in attaining your optimal health and wellness.

PATIENT INFORMATION			
Patient's Name		Today's Date:	
Address	City:	State:	ZIP Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	
Email:		Referred by:	
Date of Birth:	Age:	Social Security Number:	Sex: M / F
Occupation:		Employer:	
Spouse's Name:		Spouse's Work Phone:	
EMERGENCY CONTACT			
Emergency Contact:		Contact Phone:	
INSURANCE PROVIDER INFORMATION			
Who is responsible for this account?			
Relationship to Patient:			
Name of Health Insurance Provider:		Type of Plan:	
ID#:	Group No.:		
PERSONAL HISTORY			
Height:	Weight:	Weight one year ago:	
Adult Maximum Weight:		BP:	Cholesterol:
Known Allergies:			
Date of last physical exam:		With whom:	
Report of findings:			
Surgeries, hospitalizations, serious illnesses - (list year in brackets):			
Fracture, dislocations, major dental work - (list year in brackets):			

**PURPOSE OF APPOINTMENT**

What is the primary concern for your visit today?

Other doctors you have seen for this condition:

Have you been treated for any other conditions in the past year? If so, please describe:

Medications/Drugs you are taking:

**CONDITIONS YOU HAVE HAD:**

Check any conditions that you are currently experiencing or have had in the past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Aids/HIV            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pacemaker         |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Parasites         |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pinched Nerve     |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Poor Circulation  |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Prosthesis        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Backaches           | <input type="checkbox"/> Herniated Disk      | <input type="checkbox"/> Sinus Problems    |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Breathing Problems  | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Ulcer             |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Neuritis            | <input type="checkbox"/> Weight Loss       |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Yeast/ Candida    |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Other: _____      |

**DAILY HABITS: Do you...**

- |                     |                              |                             |                                      |                              |                             |
|---------------------|------------------------------|-----------------------------|--------------------------------------|------------------------------|-----------------------------|
| Smoke               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have sufficient energy               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drink coffee        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wear lifts or shoe supports          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Soft drinks         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Take supplements                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alcoholic beverages | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If so what? _____                    |                              |                             |
| Eat protein         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                                |                              |                             |
| Currently dieting   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                                |                              |                             |
| Eat fast food       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How much water do you drink daily? : |                              |                             |
| Sleep well          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ glasses a day                  |                              |                             |

**EXERCISE**

What sports have you played seriously?

What sports do you enjoy now?

Are you in training for a particular sport?  Yes  No

Describe:

Describe your current exercise program:

**X-RAY HISTORY**

When was your last X-Ray?

When was your last MRI?

Describe body area and type of image (X-Ray, CAT, MRI, Etc.):

**ASSIGNMENT and RELEASE**

I have read and understand my chiropractic/physical therapy benefits as explained to me. I also understand that this is strictly an estimate and not a guarantee of payment according to my insurance company. I authorize payment of medical benefits to Austin Longevity Center and the release of medical records or other information necessary for the processing of my claims.

I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services that I will be directly responsible for all charges. I also understand that any appointment without a prior 24 hour notice is subject to a fee of \$25. I authorize the use of this signature on all insurance submissions.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if there are any questions.

## We may share your health information to:

- Treat you
- Collect Payment
- Run our office
- Inform you of other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

## We may use your health information for:

- Health and safety reason
- Reporting to workers comp.
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings

## You have the right to:

- Request a copy of health records
- Request confidential communications
- Request a list of whom has been informed of your condition
- Amend your protected health information
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated

These privacy practices are effective: \_\_\_\_\_ (Date)

For further information please contact: **Austin Longevity Center at (512) 448-0900**

*I understand and agree to the following:*

- *The privacy practices have been satisfactorily explained to me and I have received a copy or had an opportunity to receive a copy of the Notice of Privacy Practices.*
- *The doctor(s) may use my confidential health information in the manner previously described.*

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date