Fedesna Chiropractic

8740 NORTH LAMAR BLVD
AUSTIN TX 78753
PH (512) 835-1182
FAX (512) 835-1888
fedesnaclinic@att.net
www.fedesna.com

BASIC INFORMATION

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State ____ Zip Code _____ Date of Birth _____

Age _____ Email _____

Employer _____ Occupation _____ Work Phone _____

Employer's Address _____

Marital Status M S W D Number of Children _____

Name of Spouse _____ Spouse's Phone _____

Name of Nearest Relative _____ Relative's Phone _____

Who referred you to this office? _____

HEALTH INFORMATION

What is the reason for your visit today? _____

Is the condition due to an on the job injury (please describe briefly)? _____

an auto accident (please describe briefly)? _____

other (please describe briefly)? _____

Date symptoms appeared or accident occurred _____ Days lost from work _____

Have you seen any other doctors for this condition? _____

What have you done for this condition? _____

HISTORY

What other medications are you taking? _____

What operations or surgery have you had? _____

INSURANCE COVERAGE (check any that apply)

❑ Regular Health Insurance ❑ Worker's Comp ❑ Medicare ❑ Medicaid

❑ Personal Injury or Auto Policy ❑ Attorney Name _____ Phone _____

Primary Coverage Insurance Company _____

Secondary Coverage Insurance Company _____

PATIENT OR GUARDIAN SIGNATURE _____ **DATE** _____

Name _____ Pt. # _____ Date _____

FUNCTIONAL RATING INDEX

For use with Neck and/or Back Problems only

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activites. For each item below, please circle the number which most closely describes your condition right now.

	0	1	2	3	4
Pain Intensity	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
Sleeping	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
Personal Care	No pain No restrictions	Mild pain No restrictions	Moderate pain Need to go slowly	Moderate pain Need some assistance	Severe pain Need 100% assistance
Travel	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
Work	Can do usual work + unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
Recreation	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities
Frequency of pain	No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day
Lifting	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
Walking	No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
Standing	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Patient Signature _____

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CONSENT OF USE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we have to use or disclose our health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notice.

Your Right to Limit Uses or Disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restrictions, the restriction is binding to us.

Your Right to Revoke your Authorization

You may revoke your consent at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have their right to your health information if they decide to contest any of your claims.

I have read the consent policy and agree to its terms.

Printed Name	Authorized Provider Representative
Signature	Date

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INFORMED CONSENT
TO CHIROPRACTIC ADJUSTMENTS AND CARE

To be completed by patient or patient's legal representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays on me (Or the patient named below, for whom I am legally responsible) by Dr. David R. Fedesna and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working along with or associated with servicing as backup for the doctor of chiropractic named above, including those working at the clinic or office listed or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time based on the facts then known, is in my best interest.

During the examination, the doctor may feel that x-rays will be needed in order to fully diagnose your condition and administer proper treatment. In order to perform x-rays on any patient, our office requires patient consent for such procedures to be performed.

I have read or have had read to me the above consent, I have also had an opportunity to ask questions about the consent, and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for me present condition and for any future condition(s) for which I seek treatment.

Print Patient's Name	Signature (Patient or Guardian)	Date