



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. # \_\_\_\_\_

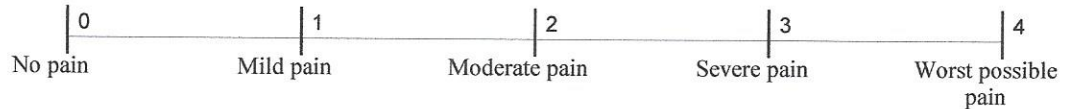
Date \_\_\_\_\_

## FUNCTIONAL RATING INDEX

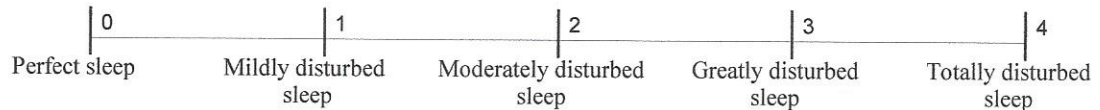
For use with Neck and/or Back Problems only

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 activities. For each item below, please circle the number which most closely describes your condition right now.

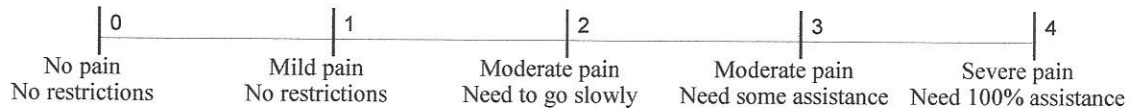
### Pain Intensity



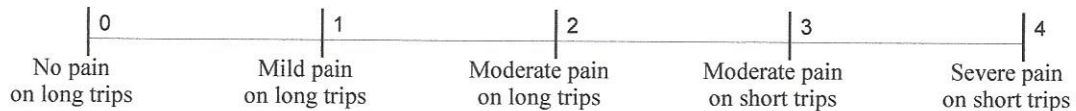
### Sleeping



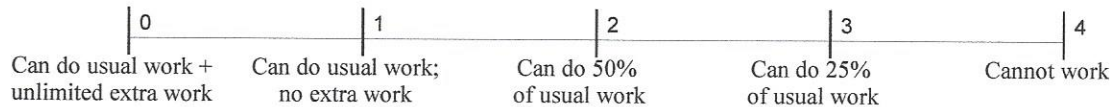
### Personal Care



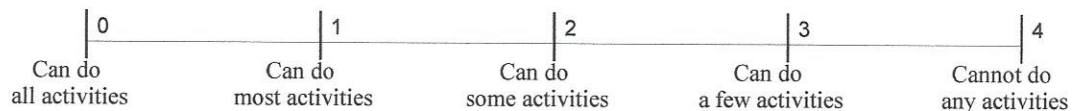
### Travel



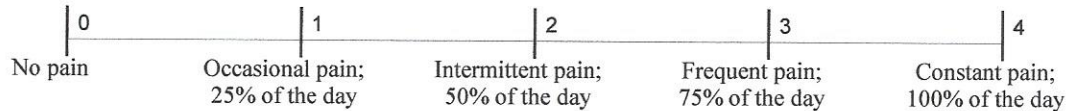
### Work



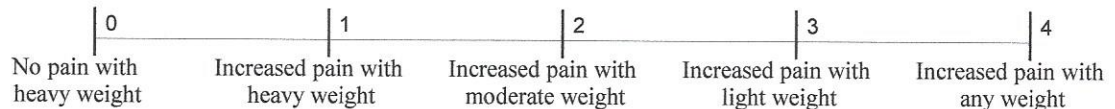
### Recreation



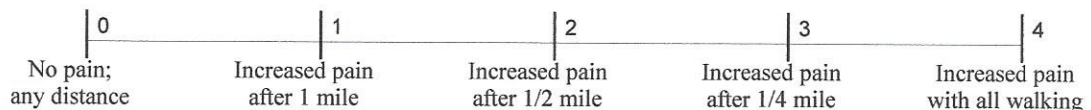
### Frequency of pain



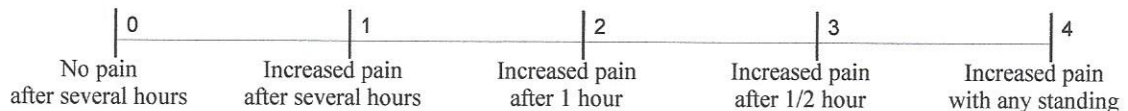
### Lifting



### Walking



### 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