WELCOME TO ACN

AUSTIN CHIROPRACTIC NEUROLOGY

Five Standards for New Patients

1. All new patients are required to fill out a personal health questionnaire.
2. You will have a personal consultation with the doctor to discuss your intake form and health concerns.
3. The doctor will perform diagnostic chiropractic, orthopedic and neurological examination procedures.
4. You will be advised if there is a need for additional procedures such as x-rays, MRI or CT Scan.
5. You will have a personal discussion with the doctor to discuss your care plan and treatment.

Confidential Patient Information

Name:			Date:
Address:		City/State/Zip:	
Home Phone:	Work:	Cell Phone:	
Email:		Date of Birth:	Current Age:

Whom may we thank for referring you? _____

Work Status: ☐Employed ☐Retired ☐Disabled ☐Full-time Student ☐Part-tme Student

Employer:	Occupation / Job Duties	
Employer Address:	City/State/Zip:	Phone:

Marital Status: ☐Married ☐Single ☐Divorced ☐Widow ☐Spouse's Name _____

FEMALES ONLY - IN REFERENCE TO RADIOGRAPHIC IMAGING

I, _____, to the best of my knowledge confirm that I am not pregnant, and waive all responsibility to the Doctor.

Signature: Date:

MINORS ONLY - CONSENT FOR TREATMENT

I hereby authorize Dr. Amir Ghazi and whomever he may so designate as her assistant, to administer chiropractic care as she deems necessary to my son/daughter, _____, date at Austin, TX this _____ day of _____, 20____.

Signature: Witnessed:

ALL PATIENTS - IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone:	Work phone:	Cell Phone:

Please list your major ailments in order of severity (from most debilitating to least debilitating):

1.	4.
2.	5.
3.	6.

1. Primary Ailment-_____

When did you first notice this condition:
Did it begin: ☐Immediate ☐Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your Symptoms spread? ☐No ☐Yes Where?
How often do you experience these symptoms? ☐Constant(100% of day) ☐Frequent(75%) ☐Often(50%) ☐Seldom(25%) ☐Rarely(less than 25%)
Is this condition progressively: ☐Worsening ☐Improving or ☐Unchanged
What is the intensity of your symptoms? ☐Severe ☐Moderate ☐Mild
Rate your symptoms on a scale of 1-10 considering 1(minimal) and 10(severe/excruciating) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Is your pain ☐Deep or ☐Superficial?
Please indicate the character of your pain: ☐Dull ☐Sharp ☐Burning ☐Aching ☐Knife-like ☐Throbbing
Are you experiencing any of the following associated symptoms? ☐Pins/Needles ☐Tingling ☐Numbness ☐Twitching If Yes, please describe:
Please indicate what activities Provoke (P) or Aggravate (A) your condition: ___Sitting for ___min., ___Standing, ___Walking, ___Lying, ___Pushing, ___Pulling, ___Lifting, ____lbs., ___Hot/Cold, ___Coughing/Sneezing, ___Bowel Movements, ___Mental Activities, ___Bright lights, ___Loud Noise, ___Other_____, ___Other_____, ___Other_____
Please indicate what helps to alleviate your symptoms: ☐Lying ☐Sitting ☐Walking ☐Standing ☐Rest ☐Heat/Cold ☐Medications_____ ☐_____ ☐_____ ☐_____

Please list what doctors/therapists you have seen for this condition: (Please include diagnosis, treatment received and any changes in your condition.

Please include any other relevant history regarding this ailment.

2. Additional Ailment-_____

When did you first notice this condition:

Did it begin: ☐Immediate ☐Gradually? Briefly describe:

What is the exact location of your symptoms:

Do your Symptoms spread? ☐No ☐Yes Where?

How often do you experience these symptoms? ☐Constant(100% of day) ☐Frequent(75%) ☐Often(50%)
. ☐Seldom(25%) ☐Rarely(less than 25%)

Is this condition progressively: ☐Worsening ☐Improving or ☐Unchanged

What is the intensity of your symptoms? ☐Severe ☐Moderate ☐Mild

Rate your symptoms on a scale of 1-10 considering 1(minimal) and 10(severe/excruciating)
. ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Is your pain ☐Deep or ☐Superficial?

Please indicate the character of your pain: ☐Dull ☐Sharp ☐Burning ☐Aching ☐Knife-like ☐Throbbing

Are you experiencing any of the following associated symptoms? ☐Pins/Needles ☐Tingling ☐Numbness ☐Twitching
If Yes, please describe:

Please indicate what activities Provoke (P) or Aggravate (A) your condition:

___Sitting for ___min., ___Standing, ___Walking, ___Lying, ___Pushing, ___Pulling, ___Lifting, ____lbs.,

___Hot/Cold, ___Coughing/Sneezing, ___Bowel Movements, ___Mental Activities, ___Bright lights, ___Loud Noise,

___Other_____, ___Other_____, ___Other_____

Please indicate what helps to alleviate your symptoms:

☐Lying ☐Sitting ☐Walking ☐Standing ☐Rest ☐Heat/Cold ☐Medications_____

☐_____ ☐_____ ☐_____

Please list what doctors/therapists you have seen for this condition: (Please include diagnosis, treatment received and any changes in your condition.

Please include any other relevant history regarding this ailment.

IF YOU HAVE MORE THAN TWO AILMENTS, PLEASE ASK THE RECEPTIONIST FOR ADDITIONAL "AILMENT" FORMS.

Past Medical History

Please include any of your previous conditions.

If possible, include: dates, diagnosis, treatment received and any residuals you still suffer from.

General Health History: Have YOU had any of the following?

Injuries, Accidents, Falls or Traumas: ☐No ☐Yes Explain:
Illnesses/ Hospitalizations: ☐No ☐Yes Explain:
Surgeries: ☐No ☐Yes Explain:
Motor Vehicle Accidents: ☐No ☐Yes Explain:
Work Injuries: ☐No ☐Yes Explain:

Females Only - Menopausal Symptoms: ☐No ☐Yes Explain:

Habits

Cigarettes/Cigars	☐None ☐Yes How much per week?
Alcohol	☐None ☐Yes How many drinks per week? Type of Alcohol?
Coffee	☐None ☐Yes How many cups per week?
Water	☐None ☐Yes Glasses per day?
Soft Drinks	☐None ☐Yes Amount per Week? Types?
Exercise	☐None ☐Yes Hours/Days per week? Types?
Sleep	Average amount per night? Hours desired per night? Do you have difficulty falling asleep or staying asleep?
Eating	Meals per day? What types of food? Do you consider your diet healthy? ☐No ☐Yes Explain:

Have any of your FAMILY MEMBERS ever suffered from any of the following conditions?

☐Diabetes ☐Heart Disease ☐Stroke ☐Neurological Disorders_____
☐Autoimmune Disorders_____ ☐Cancer_____
☐Other_____

Personal Health History

Medications: Please list your current medications, how long you have been taking them and why they are taken.
Vitamins and Minerals: Please list your current supplements.

Check the left box for any condition YOU had in the PAST, and the right box for any condition YOU have CURRENTLY.

GENERAL HEALTH HISTORY

P	C		P	C		P	C		P	C	
☐	☐	Mental Disorders	☐	☐	Diabetes	☐	☐	Pneumonia	☐	☐	Infective Disease
☐	☐	Epilepsy	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Fungal Infections
☐	☐	Tumors	☐	☐	Glaucoma	☐	☐	Hepatitis	☐	☐	Herpes
☐	☐	Alcoholism	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐	Arthritis
☐	☐	Drug Addiction	☐	☐	Rheumatic Fever	☐	☐	Parasites	☐	☐	Autoimmune Disease
☐	☐	Cancer	☐	☐	Scarlet Fever	☐	☐	Asthma	☐	☐	Chicken Pox

NERVOUS SYSTEM / EYES/EARS/NOSE/THROAT / GASTROINTESTINAL / MUSCULOSKELETAL

P	C		P	C		P	C		P	C	
☐	☐	Depression	☐	☐	Vision Problems	☐	☐	Poor/Excess Appetite	☐	☐	Jaw Pain
☐	☐	Memory Loss	☐	☐	Flashing Lights	☐	☐	Excessive Thirst	☐	☐	Difficulty Chewing
☐	☐	Confusion	☐	☐	Black Spots	☐	☐	Frequent Nausea	☐	☐	Face Pain
☐	☐	Dizziness	☐	☐	Blurriness	☐	☐	Hemorrhoids	☐	☐	Neck Pain
☐	☐	Fainting	☐	☐	Hearing Loss	☐	☐	Black/Bloody Stools	☐	☐	Arm/Elbow Pain
☐	☐	Convulsions	☐	☐	Ringing in Ears	☐	☐	Digestive Problems	☐	☐	Wrist Hand Pain
☐	☐	Weakness	☐	☐	Swallowing Difficulty	☐	☐	Abdominal Cramping	☐	☐	Mid Back Pain
☐	☐	Poor Balance				☐	☐	Gas Bloating	☐	☐	Lower Back Pain
☐	☐	Twitches/Tremor				☐	☐	Heartburn	☐	☐	Thigh/Knee Pain
☐	☐	Cold/Tingle Extremities				☐	☐	Weight Problems	☐	☐	Ankle/Foot Pain
☐	☐	Sleeping Difficulties				☐	☐	Gall Bladder Problems	☐	☐	Difficulty Walking
☐	☐	Headaches				☐	☐	Liver Problems	☐	☐	Leg/Arm Fatigue

CARDIOVASCULAR / REPRODUCTIVE / GENITOURINARY

P	C		P	C		P	C	
☐	☐	Chest Pain	☐	☐	Erectile Difficulties	☐	☐	Bladder Trouble
☐	☐	Irregular Heartbeat	☐	☐	Sexual Dysfunction	☐	☐	Painful Urination
☐	☐	High Blood Pressure	☐	☐	Menstrual Irregularity	☐	☐	Incontinence
☐	☐	Shortness of Breath	☐	☐	Menstrual Cramping	☐	☐	Discolored Urine
☐	☐	Lung/Congestion Problems	☐	☐	Venereal Infection			
☐	☐	Varicose Veins						
☐	☐	Ankle Swelling						

How many times per day do you urinate?	How often do you have a bowel movement?
Do you experience any: ☐ urgency, ☐ dribbling, ☐ incontinence?	Do your stools: ☐ Float or ☐ Sink?
Is this urination pattern consistent: ☐ Yes ☐ No	Are your bowel movements consistent? ☐ Yes ☐ No