Zygmont Chiropractic Center

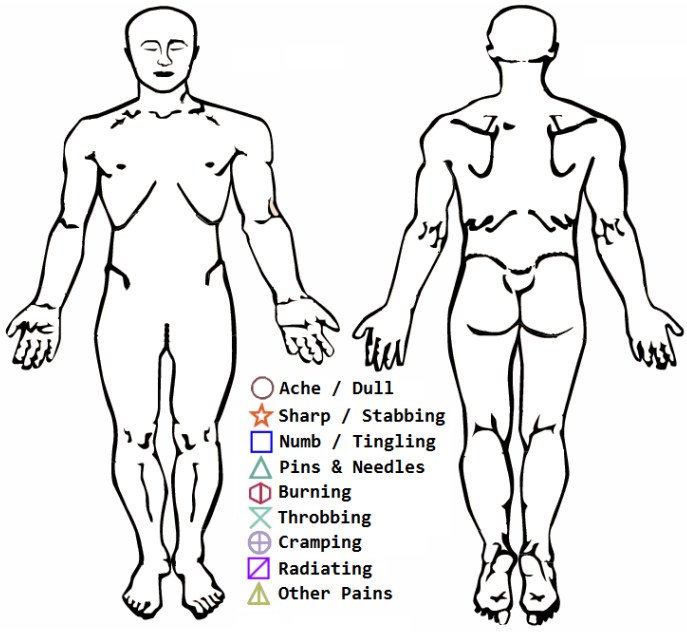
711 Garner Ave., Austin, TX 78704 Phone: 512-442-7400 zygmontchiropractic.com

You may fill out this form on your computer. Please print it out, sign it, and bring with you to your appointment.

Patient Information

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	○ Male ○ Female	Height		Weight	
Married/Civil Union		Spouse Name		# of Children	
Home #		Mobile #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Your Email					

Patient Symptoms



Patient Social

Alcohol:	☐	Daily	☐	Weekly	☐	Occasionaly	○	Never	Caffeine:	○	Daily	○	Weekly	○	Occasionaly	○	Never
Diet Food Products:	○	Daily	○	Weekly	○	Occasionaly	○	Never	Drugs:	○	Daily	○	Weekly	○	Occasionaly	○	Never
OTC Stimulants:	○	Daily	○	Weekly	○	Occasionaly	○	Never	Exercise:	○	Daily	○	Weekly	○	Occasionaly	○	Never
Homemade Food:	○	Daily	○	Weekly	○	Occasionaly	○	Never	Processed:	○	Daily	○	Weekly	○	Occasionaly	○	Never
Soft Drinks:	○	Daily	○	Weekly	○	Occasionaly	○	Never	Tobacco:	○	Daily	○	Weekly	○	Occasionaly	○	Never
Water:	○	Daily	○	Weekly	○	Occasionaly	○	Never									

Referral Information

Referring Physician: _____ Referred Patient: _____ Referred by: _____

Advertisement: ○ Yes ○ No Advertisement: _____

Referred Directory: ○ Yes ○ No Referred Directory: _____

Chiropractic Experience

Who referred you to our office: _____

Where did you hear about us? ☐ Google/Maps ☐ Bing ☐ Facebook ☐ Yelp ☐ Friend/Coworker ☐ Other _____

Have you been adjusted by a chiropractor before? ○ Yes ○ No If yes, Why? _____

Doctor's Name: _____ Approximate Date of Visit: _____

Has any member of your family ever seen a wellness chiropractor? ○ Yes ○ No

Employer Information

Employed: _____ Employer Name _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor #: _____

Work Duties: _____

Reason for this Visit

Describe the reason for this visit:

Please briefly describe, including the impact it has had on your life.

○ Wellness ○ Sports ○ Auto ○ Fall ○ Home Injury ○ Job ○ Chronic Discomfort ○ Other

Briefly Explain: _____

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ☐ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ☐ Yes ○ No Doctor's name: _____

Type of Treatment: _____

Results: ○ Good ○ Bad ○ Indifferent

Complaint Information

Injury Occurred: ◯ Work ◯ Automobile ◯ Third-Party ◯ Other Injury Date: _____

Injury Origin: _____

Describe Discomfort: _____

Interfere w/ Activities: ◯ Yes ◯ No Affected Sleep: ◯ Yes ◯ No Frequency: _____

Missed Work: ◯ Yes ◯ No Unable to Work from: _____ Unable to Work Until: _____

Affected Appetite: ◯ Yes ◯ No Explain: _____

Reduced Work: ◯ Yes ◯ No Explain: _____

Does it Worsen: ◯ Yes ◯ No Explain: _____

Weather Affects it: ◯ Yes ◯ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ◯ Yes ☐ No _____

X-rays Taken: ◯ Yes ◯ No _____

Pain level rating - Scale 1 to 10: At its best: ____ At its Worst: ____ Current Level: ____

Same condition before: ◯ Yes ◯ No Date: _____ Practitioner: _____

Family Medical History

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature: _____ Date: _____

Dry Needling Consent for Treatment

Please answer the following questions:

Are You positive for HIV/AIDS?	☐ Yes	☐ No	Do you have a bleeding disorder?	☐ Yes	☐ No
Are you taking blood thinners?	☐ Yes	☐ No	Have you had a previous spinal surgery?	☐ Yes	☐ No
Are you immunocompromised?	☐ Yes	☐ No	Have you had a breast augmentation?	☐ Yes	☐ No

Procedure: Dry Needling involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity.This can help resolve pain and muscle tension and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Like any treatment. there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with Dry Needling is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and reinflation of the lung. This is a rare complication, and in skilled hands it should not be a concern.

Other risks include injury to a blood vessel causing a bruising, infection. arrd/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. Multiple treatment sessions may be required/needed. Thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form. With my signature. I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications, which may result.

I hereby acknowledge that I have received and reviewed the above policy and asked any questions I have prior to signing.

You have the right to withdraw consent for this procedure at any time before it is performed.

_____ | _____

Patient or Guardian Signature | **Date**

_____ | _____

Patient Name (printed) | **Relationship to patient (if other than patient)**

Informed Consent for Treatment

Your Chiropractor specializes in the care of soft tissue injuries utilizing Active Release Techniques (ART) and Sound Assisted Soft Tissue Mobilization (SASTM). The first thing she will do is determine if your problem is muscular by nature. Should you need to see another professional your doctor will notify you as soon as possible. Some conditions may require 2 to 3 weeks to determine if ART or SASTM will be effective for your condition depending on how chronic your condition is.

Your sessions may be uncomfortable. Every individual's tissue tolerance is different. It is your responsibility to communicate with the doctor during and after care to give her feedback so that she can make modifications if necessary. In the event that your skin bruises after a session. communicate this to the provider so that she knows to apply less force in future treatments. She will also inform you if icing the area will help.

It is your responsibility to participate in your care by doing the stretches and exercises that you will be taught. It is also your responsibility to tell your provider whether or not you feel like the care is helping you.

I hereby authorize and release the doctor and any individual he/she may designate as her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my care.

_____ | _____

Patient or Guardian Signature | **Date**

_____ | _____

Patient Name (printed) | **Relationship to patient (if other than patient)**

Late Cancellation/ Reschedule and Missed Appointment Policy

Because we schedule a limited number of appointments each week, we need to be able to depend on these appointments to successfully operate our practice. Therefore, we have established the following office policy for missed appointments in order to improve our care for you and our other patients.

A 24 hour notice must be given for all cancelled/rescheduled appointments so that others may be scheduled in your place. If you are unable to reach us please leave a message or email to notify us of your cancellation/ rescheduling. Arriving more than 10 minutes late without informing us, or not showing up for/ missing an appointment will be considered a missed appointment. If you are running late and we have an opening, we will do our best to see you.

THE FEE FOR A LATE CANCELLATION/ RESCHEDULING OF AN APPOINTMENT, OR MISSED APPOINTMENT IS $95 AND WILL BE CHARGED TO YOUR AUTHORIZED CARD ON FILE FOR PAYMENT. This charge cannot be filed with your insurance provider.

I hereby acknowledge that I have received and reviewed the above policy and asked any questions I have prior to signing.

_____	
Patient or Guardian Signature	**Date**
_____	_____
Patient Name (printed)	**Relationship to patient (if other than patient)**