



**Robert Hagood, D.C.**  
**Injury and Wellness Center**  
 4700 Seton Center Pkwy. Ste. 115 Austin, TX 78759  
 Ph: 512.339.6635 Fax: 512.339.6637

**New Patient Paperwork**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Home # ( ) \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Email \_\_\_\_\_@\_\_\_\_\_ (For special notices and patient newsletter) Birthdate \_\_\_\_\_

Sex:  Male  Female Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed Occupation: \_\_\_\_\_

Job Functions/Work Environment \_\_\_\_\_

\_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Why did you choose us?**

health lecture mailer provider book saw our sign yellow page ad internet search engine \_\_\_\_\_

Referred by \_\_\_\_\_ other \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**Payment Information**

**Primary Card Holder Information**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_ Work # ( ) \_\_\_\_\_

**Accepted Payment Methods** cash check visa mastercard american express discover PIP/Medpay Attorney\*

\*Due to the nature of these cases, they are handled on a case by case basis

**PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary documents and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I hereby assign Dr. Robert Hagood, D.C. and whomever he may designate as his assistants to administer treatment, as they so deem necessary, and also authorize the release of any information acquired in the course of my examination and treatment. I certify that the above information is true and correct, and if any changes occur, I will notify the staff.

Printed Name \_\_\_\_\_ Patient Signature \_\_\_\_\_

Date \_\_\_\_\_





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**Patient History**

**Health History-** Please **circle** the conditions you *currently have*, and **underline** the conditions you *have had in the past*.

- |   |  |  |   |
|---|--|--|---|
| <p><u>GENERAL</u><br/>         HEADACHE<br/>         FEVER / CHILLS<br/>         NIGHT SWEATS<br/>         FAINTING<br/>         DIZZINESS<br/>         LOSS OF SLEEP<br/>         FATIGUE<br/>         NERVOUSNESS<br/>         LOSS OF WEIGHT<br/>         NUMBNESS OR PAIN IN EXTREMITIES<br/>         MENTAL/EMOTIONAL DISORDERS<br/>         ALCOHOLISM<br/>         CANCER<br/>         GOUT<br/>         DIABETES<br/>         H.I.V. / A.I.D.S.</p> <p><u>FOR WOMEN ONLY</u><br/>         PAINFUL PERIODS<br/>         EXCESSIVE FLOW<br/>         IRREGULAR CYCLE<br/>         HOT FLASHES<br/>         CRAMPS OR BACKACHES<br/>         MISCARRAIGE<br/>         ARE YOU PREGNANT? Y / N<br/>         WHAT TRIMESTER? _____</p> | <p><u>GASTRO-INTESTINAL</u><br/>         POOR APPETITE/EXCESSIVE HUNGER<br/>         POOR DIGESTION<br/>         BELCHING OR GAS<br/>         NAUSEA / VOMITING<br/>         VOMITING BLOOD<br/>         PAIN OVER STOMACH<br/>         CONSTIPATION<br/>         DIARRHEA<br/>         HEMORRHOIDS<br/>         LIVER TROUBLE<br/>         GALL BLADDER TROUBLE<br/>         ULCERS<br/>         APPENDICITIS</p> <p><u>CARDIOVASCULAR</u><br/>         RAPID/SLOW HEARTBEAT<br/>         HIGH/LOW BLOOD PRESSURE<br/>         PAIN OVER HEART<br/>         PREVIOUS HEART TROUBLE<br/>         SWELLING OF ANKLES<br/>         POOR CIRCULATION<br/>         VARICOSE VEINS<br/>         ARTERIOSCLEROSIS<br/>         HEART DISEASE<br/>         STROKE<br/>         ANEMIA</p> | <p><u>EYE/EAR/NOSE/THROAT</u><br/>         POOR VISION<br/>         PAIN IN EYES<br/>         DEAFNESS<br/>         EARACHES<br/>         NOSE BLEEDS<br/>         SORE THROAT<br/>         HOARSENESS<br/>         HAY FEVER<br/>         ASTHMA<br/>         FREQUENT COLDS<br/>         ENLARGED THYROID<br/>         TONSILITIS<br/>         SINUS TROUBLE</p> <p><u>MUSCLES &amp; JOINTS</u><br/>         WEAKNESS<br/>         TWITCHING/TREMORS<br/>         STIFF NECK<br/>         BACK ACHE<br/>         SWOLLEN JOINTS<br/>         FOOT TROUBLE<br/>         HERNIA<br/>         SPINAL CURVATURE<br/>         ARTHRITIS<br/>         "WHIP LASH" INJURY</p> | <p><u>RESPIRATORY</u><br/>         CHRONIC COUGH<br/>         SPITTING BLOOD<br/>         SPITTING PHLEGM<br/>         CHEST PAIN<br/>         TROUBLE BREATHING<br/>         PNEUMONIA<br/>         WHEEZING<br/>         TUBERCULOSIS</p> <p><u>GENITO-URINARY</u><br/>         FREQUENT URINATION<br/>         PAINFUL URINATION<br/>         BLOOD IN URINE<br/>         KIDNEY INFECTION<br/>         INABILITY TO CONTRL URINE<br/>         PROSTATE TROUBLE<br/>         VENEREAL DISEASE</p> <p><u>SKIN OR ALLERGIES</u><br/>         SKIN ERUPTIONS<br/>         ITCHING<br/>         BRUISE EASILY<br/>         ALLERGIES/HIVES<br/>         SENSITIVE SKIN<br/>         ECZEMA</p> |
|---|--|--|---|

Please list any medications you are taking, (including OTC) \_\_\_\_\_

Please list any medications you're allergic to \_\_\_\_\_

Please list previous surgeries and hospitalizations (use back if necessary) \_\_\_\_\_

**Social and Family History**

Tobacco (Packs/Day) \_\_\_\_\_ Alcohol (Drinks/Day) \_\_\_\_\_ Sleep (Hours/Day) \_\_\_\_\_ WAKING UP (#/Night) \_\_\_\_\_

EXERCISE/HOBBIES \_\_\_\_\_

Do you "POP" or "CRACK" your own spine?  YES  NO

What diseases such as cancer, high blood pressure, stroke, heart attack, diabetes, etc., do family members have?

MOTHER- \_\_\_\_\_ GRANDMOTHER- \_\_\_\_\_ BROTHERS- \_\_\_\_\_  
 FATHER- \_\_\_\_\_ GRANDFATHER- \_\_\_\_\_ SISTERS- \_\_\_\_\_  
 OTHER- \_\_\_\_\_



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### **Consent To Chiropractic Treatment**

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to myself while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications which may arise during chiropractic adjustments. Those complications may include but may not be limited to: fractures, disk injuries, dislocations, muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

**I understand that for therapeutic procedures to be fully effective, adherence to a recommended schedule of visits is imperative. Failure to comply with reasonable visit frequency is grounds for withdrawal of care by the facility. Canceled or rescheduled appointments with less than 24 hours notice may be subject to a \$25 “missed appointment” charge. Charges for missed appointments must be paid before further treatment will be offered.**

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Address of Clinic  
4700 Seton Center Pkwy.  
Ste. 115  
Austin, TX 78759

Name of Treating Doctors  
Robert Hagood, D.C.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### **Acknowledgement of Review of Notice of Privacy Practices**

I have been made aware of and/or reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_