

<b>Name:</b> _____	<b>Date:</b> /    /
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## Patient Re-Examination Form

*Please fill out the information that has changed since your last examination.*

Driver's License # \_\_\_\_\_ State of Issue \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Number of Children \_\_\_\_\_ Your employer \_\_\_\_\_ Your occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Email address \_\_\_\_\_

Primary care physician name & location \_\_\_\_\_

Have you had X-Rays?  Yes  No What body part(s)? \_\_\_\_\_ Where were they taken? \_\_\_\_\_

Women only: Are you pregnant?  Yes  No What was the first day of your last menstrual period? \_\_\_\_\_

Insurance Information (If Applicable)  No Change  Cash Payment  Insurance  Auto Accident  Job Related

Please give your card to the receptionist so that a copy may be made for your file. If the patient is not the primary card holder please give fill in the following information:

Cardholder's Name \_\_\_\_\_ Driver's License # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Cardholder's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Cardholder's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

## Initial History

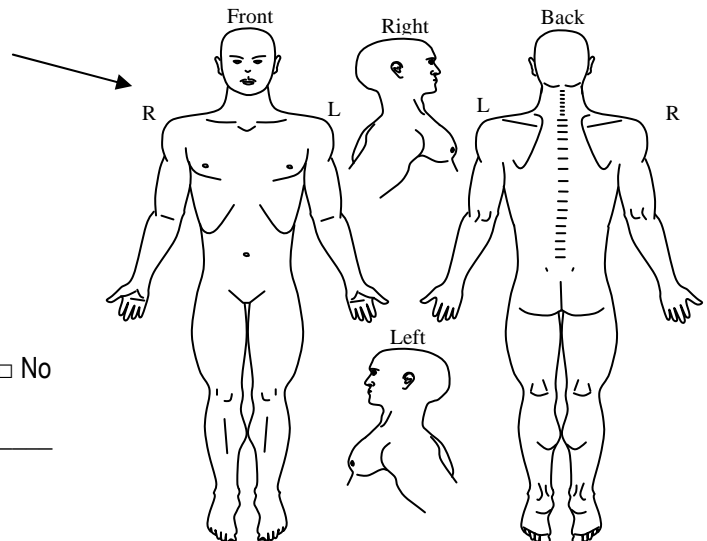
☺ Please answer every question so we can provide you with the best possible service. If you have any questions or need help filling out this form, please ask one of the staff. We will be happy to assist you.

1. What is your main complaint today? \_\_\_\_\_
2. Explain how it occurred? \_\_\_\_\_
3. When did it occur? \_\_\_\_\_ Has your condition gotten worse since it started?-----  Yes  No

4. On the figure to the right, please mark all areas of symptoms?
5. Describe what it feels like:  sharp  stabbing  dull  ache  
 tightness  pulling  burning  numbness  tingling  
 pins & needles  throbbing  other: \_\_\_\_\_

6. On the following scale please circle the intensity/severity  
 of your pain: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

7. Do your symptoms radiate or shoot to other areas?-----  Yes  No  
 a) If yes, where to? \_\_\_\_\_



8. How often do you experience your symptoms?
- a) Constantly (76-100% of the day)
  - b) Frequently (51-75% of the day)
  - c) Occasionally (26-50% of the day)
  - d) Intermittently (0-25% of the day)
9. List anything (activities, medication, etc.) that makes your condition better or worse: \_\_\_\_\_  
 \_\_\_\_\_
10. Have you previously received chiropractic care?-----  Yes  No  
 a) If yes, from whom? \_\_\_\_\_
11. Have you been treated for this complaint before?-----  Yes  No  
 a) If yes, by whom? \_\_\_\_\_ b) When was your treatment? \_\_\_\_\_
12. Has your complaint caused a change or relationship with any other parts of your body? (e.g., hearing, vision, eating, sleeping, digestion, breathing, balance, strength, or other)-----  Yes  No  
 a) If yes, what? \_\_\_\_\_
13. During the past 4 weeks how much of the time has your condition interfered with you social activities?  
 a) All of the time    b) Most of the time    c) Some of the time    d) A little of the time    e) None of the time
14. Is your current complaint related to an accident?-----  Yes  No  
 a) If yes, was it from:  Auto     Work Related     Other (describe) \_\_\_\_\_  
 b) If work related, was your employer notified?-----  Yes  No  
 c) Have you missed any work due to your accident?-----  Yes  No
15. Have you had any trauma or accidents other than normal bumps and bruises since your previous exam?-  Yes  No  
 a) If yes, what? \_\_\_\_\_
16. Have you had any illnesses other than colds, flu, since your last exam?-----  Yes  No  
 a) If yes, what? \_\_\_\_\_
17. Have you had surgery (since your last examination)?-----  Yes  No  
 a) If yes, what? \_\_\_\_\_
18. Have you had any changes in medication?-----  Yes  No  
 a) If yes, please list the medication(s) and what it is for: \_\_\_\_\_  
 \_\_\_\_\_
19. Have any of your job activities changed (lifting, sitting, standing, driving, walking, etc.)? \_\_\_\_\_
20. Have you changed any of activities you participate in? \_\_\_\_\_
21. Has there been changes in your family history? (check each that apply)  
 Arthritis     Heart disease     High blood pressure     Kidney disease     Tuberculosis     Allergies  
 Thyroid disorders     Cancer (type): \_\_\_\_\_     Other: \_\_\_\_\_

Please mark any of the following you have had difficulty with since your last exam:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Numbness in arms or hands       | <input type="checkbox"/> Stomach problems        | <input type="checkbox"/> Night pain   | <input type="checkbox"/> Loss of consciousness or momentary blackouts  |
| <input type="checkbox"/> Pins & Needles in arms or hands | <input type="checkbox"/> Kidney problems         | <input type="checkbox"/> Thyroid problems                                       | <input type="checkbox"/> Numbness or loss of feeling in the face, fingers, hand, arms, legs, or other part of your body            |
| <input type="checkbox"/> Pain in arms or hands           | <input type="checkbox"/> Bladder problems        | <input type="checkbox"/> Anemia   | <input type="checkbox"/> Weakness, clumsiness, or loss of strength in your face, fingers, hands, arms, or legs                     |
| <input type="checkbox"/> Pain in legs or feet            | <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Hernia   | <input type="checkbox"/> Sudden collapse without loss of consciousness   |
| <input type="checkbox"/> Numbness in legs or feet        | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Weakness   | <input type="checkbox"/> Sudden severe pain in the side of your head and/or neck, which is different from pain you have had before |
| <input type="checkbox"/> Pins & Needles in legs or feet  | <input type="checkbox"/> Gallbladder problems    | <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Loss of taste or smell  |
| <input type="checkbox"/> Headaches                       | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Blurred or double vision                               | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Disc problems                   | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Complete or partial loss of vision in one or both eyes | <input type="checkbox"/> Other (describe): _____   |
| <input type="checkbox"/> Jaw problems                    | <input type="checkbox"/> Sleeping problems       | <input type="checkbox"/> Ringing, buzzing or any noise in your ear(s)           | _____  |
| <input type="checkbox"/> Joint swelling                  | <input type="checkbox"/> Tension                 | <input type="checkbox"/> Recent hearing loss in one or both ears                | _____  |
| <input type="checkbox"/> Painful joints                  | <input type="checkbox"/> Lights bother eyes      | <input type="checkbox"/> Slurred speech or other speech problems                |  |
| <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Loss of balance         | <input type="checkbox"/> Difficulty swallowing                                  |  |
| <input type="checkbox"/> Chest pains                     | <input type="checkbox"/> Prostate problems       | <input type="checkbox"/> Dizziness  |  |
| <input type="checkbox"/> Heart problems                  | <input type="checkbox"/> Menstrual cramps        | <input type="checkbox"/> Temporary disorientation or confusion                  |  |
| <input type="checkbox"/> High blood pressure             | <input type="checkbox"/> Swollen ankles          |   |  |
| <input type="checkbox"/> Low blood pressure              | <input type="checkbox"/> Unexplained weight loss |   |  |
| <input type="checkbox"/> Sinus problems                  | <input type="checkbox"/> Excessive fatigue       |   |  |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Smoking                 |   |  |
|  | <input type="checkbox"/> Frequent illnesses      |   |  |

## Neck Index

### *Pain Intensity*

- 0) I have no pain at the moment.
- 1) The pain is very mild at the moment.
- 2) The pain comes and goes and is moderate.
- 3) The pain is fairly severe at the moment.
- 4) The pain is very severe at the moment.
- 5) The pain is the worst imaginable at the moment.

### *Sleeping*

- 0) I have no trouble sleeping.
- 1) My sleep is slightly disturbed (less than 1 hour sleepless).
- 2) My sleep is mildly disturbed (1-2 hours sleepless).
- 3) My sleep is moderately disturbed (2-3 hours sleepless).
- 4) My sleep is greatly disturbed (3-5 hours sleepless).
- 5) My sleep is completely disturbed (5-7 hours sleepless).

### *Reading*

- 0) I can read as much as I want with no neck pain.
- 1) I can read as much as I want with slight neck pain.
- 2) I can read as much as I want with moderate neck pain.
- 3) I cannot read as much as I want because of moderate neck pain.
- 4) I can hardly read at all because of severe neck pain.
- 5) I cannot read at all because of neck pain.

### *Concentration*

- 0) I can concentrate fully when I want with no difficulty.
- 1) I can concentrate fully when I want with slight difficulty.
- 2) I have a fair degree of difficulty concentrating when I want.
- 3) I have a lot of difficulty concentrating when I want.
- 4) I have a great deal of difficulty concentrating when I want.
- 5) I cannot concentrate at all.

### *Work*

- 0) I can do as much work as I want.
- 1) I can only do my usual work but no more.
- 2) I can only do most of my usual work but no more.
- 3) I cannot do my usual work.
- 4) I can hardly do any work at all.
- 5) I cannot do any work at all.

### *Personal Care*

- 0) I can look after myself normally without causing extra pain.
- 1) I can look after myself normally but it causes extra pain.
- 2) It is painful to look after myself and I am slow and careful.
- 3) I need some help but I manage most of my personal care.
- 4) I need help every day in most aspects of self care.
- 5) I do not get dressed, I wash with difficulty and stay in bed.

### *Lifting*

- 0) I can lift heavy weights without extra pain.
- 1) I can lift heavy weights but it causes extra pain.
- 2) I can only lift very light weights.
- 3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- 4) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 5) I cannot lift or carry anything at all.

### *Driving*

- 0) I can drive my car without any neck pain.
- 1) I can drive my car as long as I want with slight neck pain.
- 2) I can drive my car as long as I want with moderate neck pain.
- 3) I cannot drive my car as long as I want because of moderate neck pain.
- 4) I can hardly drive at all because of severe neck pain.
- 5) I cannot drive my car at all because of neck pain.

### *Recreation*

- 0) I am able to engage in all my recreation activities without neck pain.
- 1) I am able to engage in all my usual recreation activities with some neck pain.
- 2) I am able to engage in most but not all my usual recreation activities because of neck pain.
- 3) I am only able to engage in a few of my usual recreation activities because of neck pain.
- 4) I can hardly do any recreation activities because of neck pain.
- 5) I cannot do any recreation activities at all.

## ***Headaches***

- 0) I have no headaches at all.
- 1) I have slight headaches which come infrequently.
- 2) I have moderate headaches which come infrequently.
- 3) I have moderate headaches which come frequently.
- 4) I have severe headaches which come frequently.
- 5) I have headaches almost all the time.

## ***Neck Index Score* \_\_\_\_\_**

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

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## ***Back Index***

### ***Pain Intensity***

- 0) The pain comes and goes and is very mild.
- 1) The pain is mild and does not vary much.
- 2) The pain comes and goes and is moderate.
- 3) The pain is moderate and does not vary much.
- 4) The pain comes and goes and is very severe.
- 5) The pain is very severe and does not vary much.

### ***Sleeping***

- 0) I get no pain in bed.
- 1) I get pain in bed but it does not prevent me from sleeping well.
- 2) Because of pain my normal sleep is reduced by less than 25%.
- 3) Because of pain my normal sleep is reduced by less than 50%.
- 4) Because of pain my normal sleep is reduced by less than 75%.
- 5) Pain prevents me from sleeping at all.

### ***Sitting***

- 0) I can sit in any chair as long as I like.
- 1) I can only sit in my favorite chair as long as I like.
- 2) Pain prevents me from sitting more than 1 hour.
- 3) Pain prevents me from sitting more than 1/2 hour.
- 4) Pain prevents me from sitting more than 10 minutes.
- 5) I avoid sitting because it increases pain immediately.

### ***Standing***

- 0) I can stand as long as I want without pain.
- 1) I have some pain while standing but it does not increase with time.
- 2) I cannot stand for longer than 1 hour without increasing pain.
- 3) I cannot stand for longer than 1/2 hour without increasing pain.
- 4) I cannot stand for longer than 10 minutes without increasing pain.
- 5) I avoid standing because it increases pain immediately.

### ***Walking***

- 0) I have no pain while walking.
- 1) I have some pain while walking but it doesn't increase with distance.
- 2) I cannot walk more than 1 mile without increasing pain.
- 3) I cannot walk more than 1/2 mile without increasing pain.
- 4) I cannot walk more than 1/4 mile without increasing pain.
- 5) I cannot walk at all without increasing pain.

### ***Personal Care***

- 0) I do not have to change my way of washing or dressing in order to avoid pain.
- 1) I do not normally change my way of washing or dressing even though it causes some pain.
- 2) Washing and dressing increases the pain but I manage not to change my way of doing it.
- 3) Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- 4) Because of the pain I am unable to do some washing and dressing without help.
- 5) Because of the pain I am unable to do any washing and dressing without help.

### ***Lifting***

- 0) I can lift heavy weights without extra pain.
- 1) I can lift heavy weights but it causes extra pain.
- 2) Pain prevents me from lifting heavy weights off the floor.
- 3) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- 4) Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 5) I can only lift very light weights.

### ***Traveling***

- 0) I get no pain while traveling.
- 1) I get some pain while traveling but none of my usual forms of travel make it worse.
- 2) I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- 3) I get extra pain while traveling which causes me to seek alternate forms of travel.
- 4) Pain restricts all forms of travel except that done while lying down.
- 5) Pain restricts all forms of travel.

### ***Social Life***

- 0) My social life is normal and gives me no extra pain.
- 1) My social life is normal but increases the degree of pain.
- 2) Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- 3) Pain has restricted my social life and I do not go out very often.
- 4) Pain has restricted my social life to my home.
- 5) I have hardly any social life because of the pain.

### ***Changing degree of pain***

- 0) My pain is rapidly getting better.
- 1) My pain fluctuates but overall is definitely getting better.
- 2) My pain seems to be getting better but improvement is slow.
- 3) My pain is neither getting better or worse.
- 4) My pain is gradually worsening.
- 5) My pain is rapidly worsening.

## ***Back Index Score* \_\_\_\_\_**

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

## Consent to Treatment and Privacy Policy

I \_\_\_\_\_ authorize Dr. Ashley Mayland to perform chiropractic adjustments, treatments and procedures. I further consent to examinations, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments, and procedures.

### Release of Information

Dr. Ashley Mayland may disclose information from the patient's records to doctors, hospitals, or others for continuous care and to any third party who requires that information in order to fulfill an obligation benefiting the patient.

### Responsibility for Payment

I acknowledge my responsibility to and agree to pay in full for the professional services rendered. I understand that if the doctor may bill my health insurer for the services, such billing does not relieve me of my responsibility to pay for the services. I also understand a charge will be made for broken appointments unless 24 hours notice is given. I agree to pay for any costs incurred as a result of sending my bill to a collection agency or any other legal action as well as 1.5% interest per month on any money owed for service rendered.

### Informed Consent of Risks

I understand that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current condition to serious conditions such as cerebral vascular accidents. I also understand that the doctor is not liable for any problems that might arise if I decide not to follow the treatment in which he prescribes. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to sprain and strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or intern and/or other office personnel the nature and purpose of the chiropractic procedures I will receive. I understand that the doctor and/or intern will perform an examination in order to minimize any risk of care, however, I do not expect the doctor and/or intern to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or intern to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

### Medicare Patients Authorization and Assignment of Benefits

I authorize payment of government benefits to Harrisburg Family Chiropractic who accepts assignment for services covered by Medicare. I also understand it is my responsibility to pay for all other services which Medicare does not cover.

### CVA Signs

If during your visit you suffer from any of the following please notify the doctor or staff immediately:

1. Sudden severe pain in the side of your head and/or neck
2. Vision problems
3. Numbness, loss of feeling, or abnormal feeling
4. Weakness, clumsiness, or loss of strength
5. Dizziness
6. Hearing problems
7. Disorientation or confusion
8. Speech problems
9. Loss of consciousness or momentary blackouts

I have read, or have had read to me, the above consent and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment. By signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

## Privacy Policy (HIPPA)

I acknowledge that Harrisburg Family Chiropractic's "Notice of Privacy Policies" has been provided to me. I understand that I have the right to review the Privacy Policy prior to signing this document. The Privacy Policy describes my rights with respect to my protected health information which is used for treatment, the payment of bills, and in the performance of health care operations of Harrisburg Family Chiropractic Clinic. Harrisburg Family Chiropractic reserves the right to change the privacy practices that are described in the "Notice of Privacy Policies". I understand that I may obtain a revised copy of the policies by calling the office and requesting a copy or by asking for one at the time of my next appointment.

Signature: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_