Harrisburg Family Chiropractic

Name:	**Date:** / /

Patient Introduction Form

SS#_____ Date of Birth_____ Height____'____" Weight_____ lbs. Gender: □ M □ F

Driver's License #_____State of Issue _____ Marital Status_____

Address_____City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Number of Children_____ Your employer_____

Employer's Address_____

How did you hear about us?_____ Email address_____

Primary care physician name & location_____

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

Insurance Information (If Applicable) □ 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 fill in the following information:

Cardholder's Name_____ Driver's License #_____Relationship to Patient_____

Cardholders Address _____

Cardholder's Birthdate_____/_____/_____SS#_____Cardholder'sEmployer_____

Cardholder's Employer's Address_____

Initial History

☺ **Please answer <u>every</u> 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.**

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transurethral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience occasional stress	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (mother/father)	❑ Arthritis (brother/sister)	❑ Cancer (mother/father)	❑ Cancer (brother/sister)
❑ Cholesterol (mother/father)	❑ Cholesterol (brother/sister)	❑ Diabetes (mother/father)	❑ Diabetes (brother/sister)
❑ Heart problems (m/f)	❑ Heart problems (b/s)	❑ High blood pressure (m/f)	❑ High blood pressure (b/s)
❑ Psychiatric (mother/father)	❑ Psychiatric (brother/sister)	❑ Stroke (mother/father)	❑ Stroke (brother/sister)
❑ Thyroid (mother/father)	❑ Thyroid (brother/sister)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)

❑ Crystal Meth (past) ❑ Crystal Meth (present) ❑ Heroine (past) ❑ Heroine (Present)
❑ Marijuana (past) ❑ Marijuana (present)

Male Children:
❑ Under 6 years ❑ Under 10 years ❑ Under 19 years

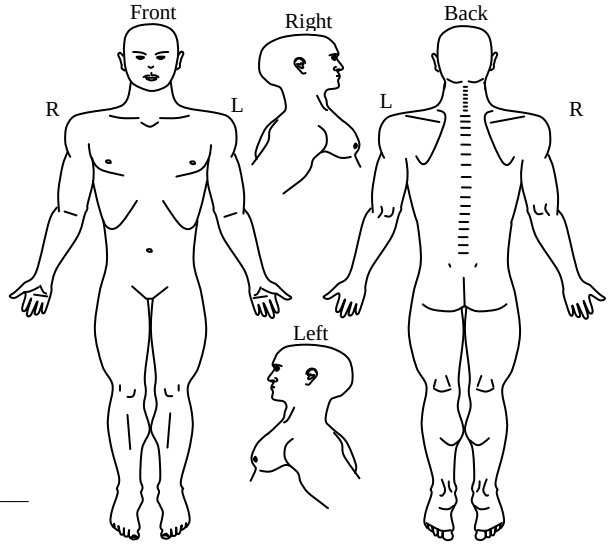
Female Children:
❑ Under 6 years ❑ Under 10 years ❑ Under 19 years

Occupational Activities:
❑ Administration ❑ Business owner ❑ Clerical/secretarial ❑ Computer user
❑ Construction ❑ Daycare/childcare ❑ Executive/legal ❑ Food service industry
❑ Health care ❑ Heavy equipment operator ❑ Heavy manual labor ❑ Home services
❑ Household ❑ Light manual labor ❑ Manufacturing ❑ Medium manual labor

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing**

0 = Pins & Needles **+ = Dull Ache**



Describe your symptoms:_____

_____

When did your symptoms start? Month_____

Day_____ **Year**_____

How did your symptoms begin?_____

How often do you experience your symptoms?

❑ Constantly (76-100% of the day) ❑ Frequently (51-75% of the day) ❑ Occasionally (26-50% of the day) ❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?
❑ Sharp ❑ Dull ache ❑ Numb ❑ Shooting
❑ Burning ❑ Tingling ❑ Stabbing

How are your symptoms changing?
❑ Getting better ❑ Not changing ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)
❑ 0 None ❑ 1 ❑ 2 ❑ 3
❑ 4 ❑ 5 ❑ 6 ❑ 7
❑ 8 ❑ 9 ❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):
❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit
❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?
❑ All of the time ❑ Most of the time ❑ Some of the time ❑ A little of the time
❑ None of the time

In general, would you say your overall health right now is….
❑ Excellent ❑ Very good ❑ Good ❑ Fair
❑ Poor

Who have you seen for your symptoms:
❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

Have you had similar symptoms in the past?
❑ Yes ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What is your occupation?

❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

If you are not retired, a homemaker or a student, what is your work status?

❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Preferred Language: _____

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.

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.

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.

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.

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.

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.

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).

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.

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.

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.

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.

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.

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.

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.

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.

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.

Harrisburg Family Chiropractic
220 S. Cliff Ave. Ste 106
Harrisburg SD 57032
(605) 767-7463

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: _____ **Date:** _____

Relationship to Patient: _____