HUMPAL CHIROPRACTIC

Please allow our staff to photocopy your driver's license and insurance details.

First Name _____ Last Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Primary Phone _____ Secondary Phone _____
Email _____ Date of Birth _____ ☐ Male ☐ Female
Social Security Number _____ Age _____
Occupation _____ Employer _____
Marital Status ☐ S ☐ M ☐ D ☐ W Spouse Name _____
Number of Children/Ages _____
Who may we thank for referring you to our office? _____

1. Symptoms and Present State of Health

Reason for seeking care in this office today _____
Complaint **started on** _____
Since it began, is it ☐ Same ☐ Better ☐ Worse
How did injury/pain occur? _____
What activities **aggravate** your condition? _____
What activities **lessen** your condition? _____
What time of the day is this condition the worst?
☐ Morning ☐ Midday ☐ Evening ☐ Night ☐ All Day ☐ All Night
Is this condition interfering with ☐ Work ☐ Sleep ☐ Routine ☐ Other
Other doctors seen and home remedies tried, to treat this condition? _____
Are you under medical care for any conditions?
Are you experiencing changes in bowel or bladder function? ☐ Y ☐ N If yes, explain _____

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2. Chiropractic and Physical Therapy History

Have you ever received Chiropractic Care ☐ Y ☐ N Physical Therapy ☐ Y ☐ N
When was your last Chiropractic treatment? _____ PT treatment? _____
Previous Chiropractor(s) _____ PT(s) _____
Were you satisfied with your previous Chiropractic Care? ☐ Y ☐ N Physical Therapy? ☐ Y ☐ N
Please explain _____

3. What are you aiming to achieve from care in this office? *Check all that apply. If unsure, leave blank.*

CARE TYPE	PURPOSE
☐ Acute Care	Temporary pain relief
☐ Supportive Care	Slow progression of condition or maintain current health status
☐ Wellness Care	Prevention treatment as a healthy lifestyle choice

4. What services are you interested in? *Check all that apply. If unsure, leave blank.*

☐ Adjustments
☐ Muscle Release Techniques or Provider Assisted Stretching
☐ Electrical Stimulation, Ultrasound, or Ice Therapies
☐ Massage - licensed LMT on staff
☐ Physical Therapy – licensed PT on staff

Chief Complaint Form

1. CHECK the words that best describe the symptoms or complaint you are experiencing:

☐ Dull Achy ☐ Pins and Needles ☐ Stabbing ☐ Spasms ☐ Sharp
☐ Radiating/Traveling ☐ Numbness ☐ Burning ☐ Shooting ☐ Other

2. CHECK the phrase that best describes how often you have your symptoms or complaint: (Check One)

☐ INFREQUENTLY ☐ SOME OF THE TIME ☐ MOST OF THE TIME ☐ ALL OF THE TIME

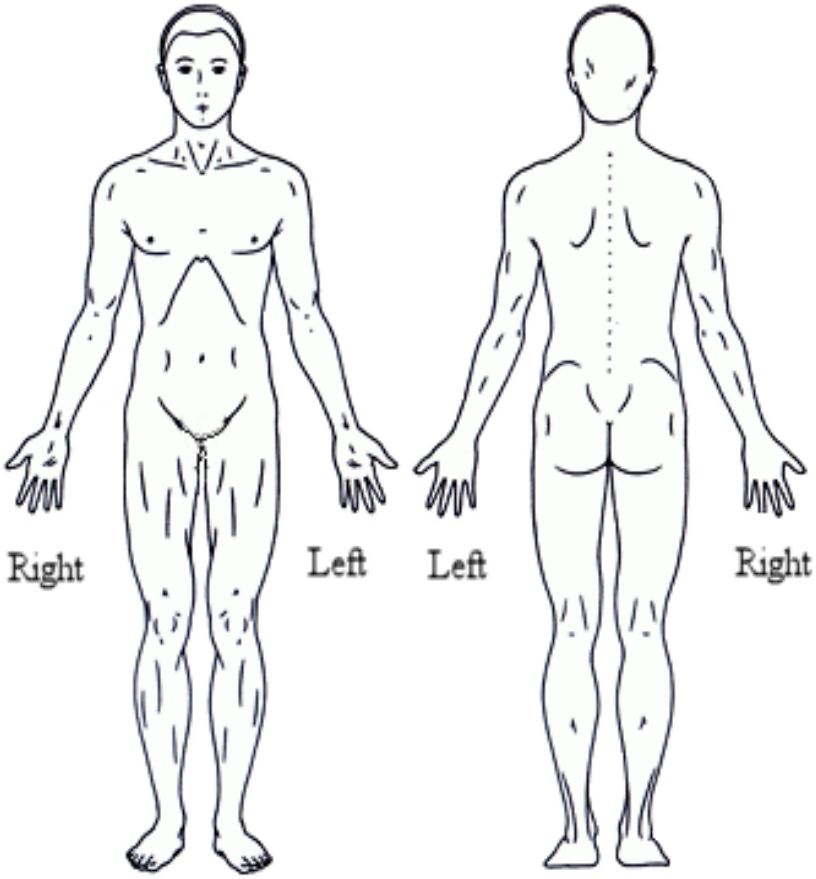
3. CHECK a number to indicate the intensity of symptoms or complaint on the scale below:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain **Worst Pain Possible**

Using the symbols below, mark on the pictures where you feel your symptoms or complaint:

Dull Achy	**XXX**
Numbness	**OOO**
Pins/Needles	///
Burning	**+++**
Stabbing	^ ^ ^
Shooting	**TTT**
Spasms	**###**
Can't describe	**???**
Tight	**= = =**
Weak	**~ ~ ~**
Other _____	*******



4. <u>Patient Specific Functional Scale:</u> Please list TWO activities that are currently limited due to your symptoms. Rate them on a scale from 0-10. (0 = unable to perform activity. 10 = able to perform activity at same level as before injury)

1. _____ **Rating (0-10)** _____

2. _____ **Rating (0-10)** _____

5. <u>Health/Wellness Goals:</u> In 4-6 weeks I'd like to… **in the next year, I'd like to...**

_____ _____

I. PAST MEDICAL HISTORY

a. **Surgeries**

Type: _____ Date Performed: _____
Type: _____ Date Performed: _____
Type: _____ Date Performed: _____

b. **Accidents/Trauma/Fractures**

Type: _____ Date Performed: _____
Type: _____ Date Performed: _____

c. **ER Visits/Hospitalizations**

Type: _____ Date Performed: _____
Type: _____ Date Performed: _____

II. FAMILY HISTORY

a. Mother: Age (*if living*) _____ Age (*at death*) _____ Cause of death _____
b. Father: Age (*if living*) _____ Age (*at death*) _____ Cause of death _____

Is there a Family History of:	Heart Disease	Arthritis	Cancer	Diabetes	Other
Mother's side:	☐	☐	☐	☐	☐
Father's side:	☐	☐	☐	☐	☐ _____

c. Other Blood Relatives: Relationship _____ Conditions _____
d. Other Blood Relatives: Relationship _____ Conditions _____

III. LIFESTYLE HISTORY

a. Have you ever been pregnant? ☐ Yes ☐ No ☐ N/A *If yes, how many births?* _____
Cesarean Birth? ☐ Yes ☐ No *Any complications:* _____
b. Smoking Status: ☐ Every Day ☐ Light Smoker ☐ Heavy Smoker
Date/Year Quit: _____ ☐ Never Smoked ☐ Former Smoker
Current Smokers answer the following:
Do you believe you can… Quit smoking in the next 6 months? ☐ Yes ☐ No
Quit smoking in the next month? ☐ Yes ☐ No *Set a date to quit smoking?* ☐ Yes ☐ No
c. Do you drink alcohol? ☐ Yes ☐ No *If yes, how much?* _____ *how often?* _____
d. Do you take street or recreational drugs? ☐ Yes ☐ No
e. Do you currently take medications? ☐ Yes ☐ No *List meds & reason for taking?*
_____
f. Herbal or Dietary Supplements? ☐ Yes ☐ No *List supplements & reason for taking?*
_____
g. Number of meals per day: _____ *Number of "fast food" meals per week?* _____
h. Have you gained or lost 10 pounds in the last 6 months without wanting to? ☐ Yes ☐ No
i. Exercise regularly? ☐ Yes ☐ No *how long?* _____ *how often?* _____
j. Are you employed or self-employed? ☐ Yes ☐ No Place of employment? _____
k. Have you had any work-related illness or injuries? ☐ Yes ☐ No
If yes, please explain: _____ *Injury/Illness* _____ *Date* _____
l. How much are **Hobbies affected by your condition**?
☐ Mildly ☐ Moderately ☐ Significantly ☐ Can't Do

Check Hobbies affected: ☐ fishing ☐ hunting ☐ quilting ☐ reading
☐ playing sports ☐ playing w/kids ☐ other _____

m. How much are **Daily Activities affected by your condition**?
☐ Mildly ☐ Moderately ☐ Significantly ☐ Can't Do

Check ADL's affected:

☐ pet care	☐ gardening	☐ computer use	☐ getting in/out of bed		
☐ sitting	☐ running	☐ walking	☐ yard work	☐ exercising	☐ reaching overhead
☐ laundry	☐ jogging	☐ standing	☐ cleaning	☐ lifting child	☐ carrying groceries
☐ driving	☐ working	☐ sleeping	☐ self-care	☐ feeding/eating	
☐ other _____					

IV. PAST OR PRESENT MEDICAL CONDITIONS

What **conditions** do you **have** or have you **had**? *(Please Check and Date)*

CONDITION	DATE	CONDITION	DATE
Musculoskeletal:		**Blood/Immune System**	
☐ Neck pain		☐ High cholesterol/triglycerides	
☐ Mid back pain		☐ High glucose	
☐ Low back pain		☐ Hypothyroidism	
Headaches:		☐ Hyperthyroidism	
☐ Mild ☐ Moderate ☐ Severe		☐ Diabetes	
☐ Daily ☐ Weekly ☐ Monthly		☐ Sinus infections	
Numbness/Tingling:		☐ Ear infections	
☐ Arm ☐ Forearm ☐ Hands		**Digestive System:**	
☐ Thigh ☐ Leg ☐ Foot		☐ Acid reflux/GERD	
☐ Foot/Ankle pain		☐ Peptic ulcer *(gastric/duodenal)*	
☐ Hip pain		☐ Constipation	
☐ Knee pain		☐ Irritable bowel syndrome	
☐ Elbow pain		☐ Nausea	
☐ Carpal tunnel		☐ Vomiting	
☐ Dizziness		☐ Abnormal stools/blood in stools	
☐ Arthritis (OA)		**Vasculature:**	
☐ Rheumatoid arthritis (RA)		☐ Varicose veins	
☐ Sciatica		☐ Blood clots	
☐ Herniated/Degenerative disc condition		☐ Stroke/TIA	
☐ Fibromyalgia		☐ Peripheral Artery Disease	
☐ Earaches		☐ Hardening of the arteries	
☐ Abnormal X-Ray or MRI findings		**Lungs:**	
☐ Shoulder pain		☐ Pneumonia	
☐ Wrist pain		☐ Asthma	
Heart:		☐ Bronchitis	
☐ High blood pressure		☐ COPD	
☐ Heart attack		☐ Emphysema	
☐ Angina		☐ Difficulty breathing	
☐ Congestive heart failure		**Other Conditions:**	
Nervous system:		☐ Chest pressure/tightness w/exertion	
☐ Neuralgia		☐ Chest pressure/tightness w/rest	
☐ Migraines		☐ Generalized weakness	
☐ Stress/Cluster headaches		☐ Cancer	
☐ Pinched nerves		Type _____	
☐ Depression		☐ Night sweats	
☐ Panic Attacks/Anxiety		☐ Feeling faint or passing out	
☐ Blurry or Double vision		☐ Pain in legs while walking	
Organ System:		☐ Recent weight loss	
☐ Kidney stones		# Pounds lost _____	
☐ Gallstones		☐ Recent weight gain	
☐ Hepatitis		# Pounds gained _____	
☐ Bladder infections		☐ Swollen feet or ankles	
☐ Enlarged prostate			

V. HEALTH MAINTENANCE

Primary Care Physician: _____

Males

a. Date of last physical exam: _____
b. Date of last blood test: _____
c. Date of last prostate exam: _____

Females

a. Date of last physical exam: _____
b. Date of last blood test: _____
c. Date of last bone density exam: _____

HUMPAL CHIROPRACTIC

INFORMED CONSENT

PATIENT NAME: _____ DATE: _____

Attention patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, exam/eval and treatment, you are consenting to the following procedures:

☐ **Humpal Chiropractic may provide the necessary exam(s)/treatment(s) for my condition**

Spinal manipulative therapy	Palpation	Physical Therapy
Extremity manipulative therapy	Orthopedic testing	Therapeutic exercises/activities
Muscle strength testing	Postural analysis	Neuromuscular reeducation
Electrical stim	Hot/cold therapy	Myofascial release
Radiographic studies	Mechanical traction	
Ultrasound	Stretching/activation of muscles	

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization and/or Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Assignment, Release, Privacy and Payment

- I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.
- An x-ray exam may be hazardous to an unborn child, and I certify that to the best of my knowledge I am not pregnant. **Date of last menstrual period (MM/DD/YYYY):** _____
- I may be contacted to confirm/reschedule an appointment and to be sent occasional cards, letters, emails, or health information as an extension of my care in this office. You may be receiving automated SMS text message. If you would rather opt-out, please notify us.
- **I am responsible for payment of any covered or non-covered services I receive. I understand a quote of insurance benefits is not a guarantee of my chiropractic and physical therapy insurance coverage.** Any health or accident insurance I may have is an agreement between the carrier and myself. I assign to Humpal Chiropractic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. *Copays, deductibles, coinsurances, and all other fees may be collected at time of service. Accounts not paid within 60 days of the date of service are subject to a 10% monthly finance charge.*
- **Health Savings Accounts** or **Flexible Spending Accounts** may be used for copays, coinsurances, deductibles, and services received at Humpal Chiropractic, LLC. Patient is responsible for substantiating these payments as required by their employer/insurer.
- To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. I understand it is my responsibility to inform this office of any changes in my health.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read or have had read to me the above explanation of the chiropractic adjustment, related treatment, assignment, release, privacy, and payment. I have discussed these topics with the appropriate treating chiropractor or physical therapist and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Initial Visit

Date: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)