

Harris Chiropractic Clinic

Chart No. _____ Patient Case History Date _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Social Security #: _____ Gender: Male Female No. of Children: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact Method: Home Cell Work E-mail

Occupation: _____ Employer: _____

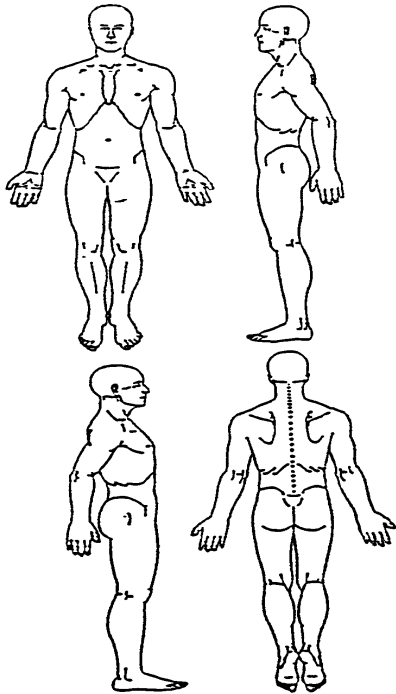
Employer's Address: _____ Work Phone: _____

Are you currently off work due to your condition? Yes No Not Applicable

Name of Spouse: _____ How did you learn of this clinic? _____

Emergency Contact: _____ Phone: _____

Mark on the picture below to illustrate your complaints. Number each separate complaint with #1 being your major complaint.



Reason for consulting this office: *(may check more than one)*

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level
- Maintenance/Supportive/Wellness care
- Nutritional Consultation

Have you ever had chiropractic care? Yes No

When? _____

Why? _____

Where? _____

When was your last adjustment? _____

Have you seen any other doctor for this condition?

No Yes Who? _____

Have you been treated by a doctor for any other health condition in the last year? Yes No

Describe: _____

Did this condition occur while working at your place of employment? Yes No

Have you had any x-rays or M.R.I.s within the last 2 years? Yes No If yes, when? _____

If yes:

What areas were viewed? (low back, neck, shoulder, etc.) _____

Where were these taken? _____ Phone: _____ Fax: _____

Name: _____ Chart #: _____ Date: _____

Describe complaint #1 _____ Date problem began? _____

Have you had this condition in the past? Yes No If yes, when? _____

How did this problem begin (falling, lifting, etc.)? _____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling
Radiating Pain Tightness Stabbing Throbbing Other: _____

How is your condition changing? Getting Better Getting Worse Not Changing		How do your symptoms affect your ability to perform daily activities such as working or driving? (0= no effect and 10= no possible activities)
How often do you experience your symptoms? (% of the day)	Rate your pain	
Constantly (76-100%)	1 2 3 4 5 6 7 8 9 10	
Frequently (51-75%)	Cannot work -	
Occasionally (26-50%)	Take me to the E.R. -	0 1 2 3 4 5 6 7 8 9 10
Intermittently (0-25%)		

Staff use only

Describe complaint #2 _____ Date problem began? _____

Have you had this condition in the past? Yes No If yes, when? _____

How did this problem begin (falling, lifting, etc.)? _____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling
Radiating Pain Tightness Stabbing Throbbing Other: _____

How is your condition changing? Getting Better Getting Worse Not Changing		How do your symptoms affect your ability to perform daily activities such as working or driving? (0= no effect and 10= no possible activities)
How often do you experience your symptoms? (% of the day)	Rate your pain	
Constantly (76-100%)	1 2 3 4 5 6 7 8 9 10	
Frequently (51-75%)	Cannot work -	
Occasionally (26-50%)	Take me to the E.R. -	0 1 2 3 4 5 6 7 8 9 10
Intermittently (0-25%)		

Staff use only

Describe Complaint #3 _____ Date problem began? _____

Have you had this condition in the past? Yes No If yes, when? _____

How did this problem begin (falling, lifting, etc.)? _____

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling
Radiating Pain Tightness Stabbing Throbbing Other: _____

How is your condition changing? Getting Better Getting Worse Not Changing		How do your symptoms affect your ability to perform daily activities such as working or driving? (0= no effect and 10= no possible activities)
How often do you experience your symptoms? (% of the day)	Rate your pain	
Constantly (76-100%)	1 2 3 4 5 6 7 8 9 10	
Frequently (51-75%)	Cannot work -	
Occasionally (26-50%)	Take me to the E.R. -	0 1 2 3 4 5 6 7 8 9 10
Intermittently (0-25%)		

Staff use only

Request an additional page if needed from a staff member.



Oswestry Disability Index For Low Back

Name _____

Chart # _____

Date _____

This questionnaire will give Dr. Harris information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- (0) I can tolerate the pain I have without having to use pain killers.
- (1) The pain is bad but I manage without taking pain killers.
- (2) Pain killers give complete relief from pain.
- (3) Pain killers give moderate relief from pain.
- (4) Pain killers give very little relief from pain.
- (5) Pain killers have no effect on the pain and I do not use them.

Personal Care

- (0) I can look after myself 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) Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned (e.g., on a table).
- (3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- (4) I can only lift very light weights.
- (5) I cannot lift or carry anything at all.

Walking

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than 0.5 miles.
- (3) Pain prevents me from walking more than 0.25 miles.
- (4) I can only walk using a stick or crutches.
- (5) I am in bed most of the time and have to crawl to the toilet.

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- (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. (e.g., recliner)
- (2) Pain prevents me sitting more than 1 hour.
- (3) Pain prevents me from sitting more than 30 minutes.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

Standing

- (0) I can stand as long as I want without extra pain.
- (1) I can stand as long as I want but it gives me extra pain.
- (2) Pain prevents me from standing for more than 1 hour.
- (3) Pain prevents me from standing for more than 30 minutes.
- (4) Pain prevents me from standing for more than 10 minutes.
- (5) Pain prevents me from standing at all.

Sleeping

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using sleeping tablets.
- (2) Even when I take sleeping tablets I have less than 6 hours of sleep.
- (3) Even when I take sleeping tablets I have less than 4 hours of sleep.
- (4) Even when I take sleeping tablets I have less than 2 hours of sleep.
- (5) Pain prevents me from sleeping at all.

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- (0) My sex life is normal and causes no extra pain.
- (1) My sex life is normal but causes some extra pain.
- (2) My sex life is nearly normal but is very painful.
- (3) My sex life is severely restricted by pain.
- (4) My sex life is nearly absent because of pain.
- (5) Pain prevents any sex life at all.

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- (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 effect on my social life apart from limiting energetic interests such as dancing.
- (3) Pain has limited my social life and I do not go out as often.
- (4) Pain has restricted my social life to my home.
- (5) I have no social life because of pain.

u

- (0) I can travel anywhere without extra pain.
- (1) I can travel anywhere but it gives me extra pain.
- (2) Pain is bad but I manage journeys over 2 hours.
- (3) Pain restricts me to journeys of less than 1 hour.
- (4) Pain restricts me to short necessary journeys under 30 minutes.
- (5) Pain prevents me from traveling except to the doctor or hospital.

_____ Initials

Index Score = [sum of all sections answered / (# of sections answered X 5)] X 100

Index Score _____

Neck Index

Name _____

Chart # _____

Date _____

This questionnaire will give Dr. Harris information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- (0) I have no pain at the moment.
- (1) The pain is mild at the moment.
- (2) The pain comes and goes and is moderate.
- (3) The pain is moderate and does not vary much.
- (4) The pain is severe but comes and goes.
- (5) The pain is severe and does not vary much.

Personal Care

- (0) I can look after myself 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) Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned (e.g., on a table).
- (3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- (4) I can only lift very light weights.
- (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 cannot read as much as I want 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 in concentrating when I want to.
- (3) I have a lot of difficulty in concentrating when I want to.
- (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 to.
- (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 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 can engage in all recreational activities with no neck pain.
- (1) I can engage in all recreational activities with some neck pain.
- (2) I can engage in most, but not all, recreational activities because of neck pain.
- (3) I can engage in only a few of my usual recreational activities because of neck pain.
- (4) I can hardly do any recreational activities because of neck pain.
- (5) I cannot do any recreational activities at all.

_____ Initials

Index Score = [sum of all sections answered / (# of sections answered X 5)] X 100

Index Score _____

Patient Health History

Harris Chiropractic Clinic

Name: _____

Chart No: _____

Date: _____

Mark any Allergies:

Animals	Aspirin/Pain Medicine	Bee Stings	Chocolate/Sweets
Dairy Products	Dust	Eggs	Latex
Molds	Penicillin	Ragweed/Pollen	Rubber
Seasonal Allergies	Shellfish	Soaps	Wheat
X-ray Dye	Other: _____		

Mark any types of medications you are taking:

Allergy	Anti-depression	Anxiety	Birth Control
Cardiovascular	Insulin	Muscle Relaxors	Pain Killers
Other: _____			

Mark all past and current health conditions:

Current	Current	Current	Current
Past	Past	Past	Past
MUSCULOSKELETAL SYSTEM	FEMALE	GENITOURINARY SYSTEM	
Ankle pain	Breast pain	Bladder trouble	Low blood pressure
Arm pain/problems	Lumps on the breast	Discolored urine	Pacemaker
Arthritis	Menstrual Problems	Excessive urination	Stroke
Broken bones	Vaginal bleeding	Scanty urination	EYE
Elbow pain	Vaginal discharge	Painful urination	Eye inflammation
Foot pain	Vaginal pain	ILLNESSES	Eye strain
Genetic spinal disorder	ARE YOU PREGNANT?	Cancer	Vision problems
Hand pain	Yes No	Diabetes	EAR
Hip pain	MALE	Hepatitis	Ear discharge
Jaw pain	Prostate problems	Tumor	Ear pain
Joint stiffness	GASTROINTESTINAL	NERVOUS SYSTEM	Hearing loss
Knee pain	Abdominal pain	Depression	Hearing problems
Leg pain/problems	Black stool	Dizziness	NOSE
Low back pain	Bloody stool	Epilepsy	Difficulty breathing
Mid back pain	Constipation	Fainting	through nose
Multiple Sclerosis	Diarrhea	Fatigue	Nose bleeding
Neck pain	Difficulty chewing	Fibromyalgia	Nose discharge
Pain between shoulders	Difficulty swallowing	Headaches	Nose pain
Painful joints	Excessive hunger	Neurological disorder	Sinus
Shoulder pain	Excessive thirst	Other disorder	MOUTH & THROAT
Sore muscles	Gall bladder problems	Parkinson's Disease	Dental problems
Spasms	Hemorrhoids	Polio	Difficulty speaking
Sprain/Strain	Liver trouble	Spinal cord injury	Hoarseness
Swollen joints	Nausea	CARDIOVASCULAR &	Sore gums
Walking problems	Poor appetite	RESPIRATORY	Sore mouth
Weak muscles	Significant weight change	Asthma	
Wrist pain	Stomach problems	Chest Pain	
	Ulcer(s)	Heart attack	
	Vomiting blood	High Blood Pressure	

Notes: (Feel free to use this space for additional questions or comments for Dr. Harris)

Patient Health History

Harris Chiropractic Clinic

Name: _____

Chart No: _____

Date: _____

Mark any Surgeries:

Appendix	Back	Brain	Carpal tunnel	Cervical Disk
Chest	Dental	Disk	EENT	Elbow
Foot	Gallbladder	Gastrointestinal	Gynecological	Heart
Heart Bypass	Hernia	Hip	Hip Replacement	Knee
Knee Replacement	Lumbar Disk	Neck	Neurological	Obstetrical
Pediatric	Shoulder	Thoracic Disk	Tonsils	Wrist

Other: _____

Date of last physical examination: _____

Do you smoke? No Yes

Do you drink alcohol? No Yes - how often? _____

Do you drink coffee or tea? No Yes - how many servings per day? _____

Do you exercise? No Yes - what forms and how often? _____

Do you abuse drugs? No Yes

Family History

Cancer	Relation (Mother, Father, Sibling) _____
Diabetes	Relation (Mother, Father, Sibling) _____
Heart Disease	Relation (Mother, Father, Sibling) _____
High Blood Pressure	Relation (Mother, Father, Sibling) _____
Other: _____	Relation (Mother, Father, Sibling) _____

I do not have family history of any of the above.

Describe any Prior Injuries

Auto Injury: _____ Date of injury: _____

Work Injury: _____ Date of injury: _____

Falls/Accidents: _____ Date of Injury: _____

I have no prior injuries.

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system and spine, which can result in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

About Your Care

There are three phases of care that Chiropractic patients often go through. The first Initial Intensive Care which corrects the most recent layer of Spinal and Neurological damage. This care often reduces or eliminates the symptoms. Then begins Reconstructive Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. At Harris Chiropractic Clinic, our mission is to help you achieve and maintain your greatest health expression.

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs and electric muscle stimulation may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Printed Name

Signature

Date

WITNESS:

Printed Name

Signature

Date

X-ray Consent

I (name) _____ do hereby give my consent to Harris Chiropractic Clinic and its representative to take x-rays as deemed appropriate by the examining doctor of Chiropractic. I do hereby declare that to my knowledge I am not pregnant.

(Signature)

(Date)

Insurance Assignment
For Harris Chiropractic Clinic

Name: _____ Chart #: _____ Date: _____
Insurance Company: _____ Phone: _____ Member ID: _____
Policyholder Name: _____ Policyholder Date of Birth: _____
Group Number: _____

Assignment of benefits:

I hereby instruct and direct _____, the Insurance Company, to pay by check made out and mailed directly to: Dennis A. Harris, D.C. Tax I.D. #. 752280707. The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of the Assignment shall be considered as effective and valid as the original.

Patient/Guardian Signature

Date

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by **Harris Chiropractic Clinic** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

Your may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient (print)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

Office Representative

Date

Others we may release your PHI to