

HEALING TOUCH

**Chiropractic,
Sports Medicine &
Spine Rehabilitation**

Today's Date: _____ Patient SS# _____ Patient Office ID: _____

Patient Name _____ Employer _____

Address: _____ Address: _____

City State Zip City State Zip

Sex M F Age _____ Date of Birth _____ Single Married Widowed Separated Divorced

Home Phone _____ Work Phone _____ Cell _____

Best time and place to reach you _____ Email: _____

Occupation _____ Employer Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Spouse's Occupation _____ Spouse's Employer _____

How did you hear of Healing Touch? Advertisement Friend At an Event Other: _____

Whom may we thank for referring you? _____

In Case of Emergency contact

Name _____ Relationship _____ Hm Phone _____ Wk Phone _____

Insurance Information

Subscriber's Name: _____ Birth Date _____ Relationship to Patient _____

Insurance Company Name: _____ Policy# _____

Insurance Company Address: _____ Group/Claim # _____

SS# _____

Is patient covered by additional insurance? Yes No

Subscriber's Name: _____ Birth Date _____ Relationship to Patient _____

Insurance Company Name: _____ Policy# _____

Insurance Company Address: _____ Group/Claim # _____

SS# _____

For No Fault and Worker's Compensation:

Attorney Information (for personal injury, WC, No Fault)

Name:: _____ Contact Person: _____

Address: _____ Phone: _____

City State Zip Date of Injury: _____ State: _____ Time: _____

City State Zip Date of Injury: _____ State: _____ Time: _____

Informed Consent to Care

(Patient: Please discuss any questions or concerns with the Doctor before signing this consent.)

I hereby request and consent to the performance of Manipulation (adjustments) and other procedures including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of Manipulations (adjustments) and other treatments outlined below. Alternatives to treatment have been reviewed.

I understand that I will be receiving one or more of the following treatments: Manipulation/ Mobilization Therapy, Hot/Cold packs, Ultrasound, Myofascial Release, Traction, EMS, Therapeutic exercises, Massage, Graston Technique, and/or Kinesio Taping.

I understand that Manipulation is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient X _____ Date _____ Doctor's Signature _____ Date _____
(or guardian)

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am financially responsible for all charges whether or not paid by the insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original.

Signature of Patient X _____ Date _____ Doctor's Signature _____ Date _____
(or guardian)



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Chief Complaint Questionnaire

1. Reason for Visit, If this is a motor vehicle accident or on the job injury please also fill out the appropriate forms

2. What do you hope will happen as a result of this visit?

3. When did your symptoms appear? Pick one

- I don't know how it began It comes and goes I've had it a long time (about _____ years)
- Specific injury (date of injury _____) On-the-job

4. Explain how the injury happened

5. Overall my state of health is Excellent Good Fair Improving Failing

6. Rate the severity of your **low back** pain on a scale from 1 (least pain) to 10 (severe pain)

1. right now ____/10 2. At its worst today ____/10 3. At its worst overall since beginning ____/10

7. Rate the severity of your **leg pain** on a scale from 1 (least pain) to 10 (severe pain)

1. right now ____/10 2. At its worst today ____/10 3. At its worst overall since beginning ____/10

8. Rate the severity of your **neck pain** on a scale from 1 (least pain) to 10 (severe pain)

1. right now ____/10 2. At its worst today ____/10 3. At its worst overall since beginning ____/10

9. Rate the severity of your **arm pain** on a scale from 1 (least pain) to 10 (severe pain)

1. right now ____/10 2. At its worst today ____/10 3. At its worst overall since beginning ____/10

10. Rate the severity of your _____ **pain** on a scale from 1 (least pain) to 10 (severe pain)

1. right now ____/10 2. At its worst today ____/10 3. At its worst overall since beginning ____/10

11. Do you have the following problems? Please circle your answer

Weakness arms hands legs feet none

Numbness (loss of feeling) arms hands legs feet none

Tingling (falling asleep) arms hands legs feet none

12. Is your pain worse at night Yes No. Does your pain awaken you from sleep? Yes No

13. Does coughing affect your pain Yes No. Do your legs hurt/tire when you walk far? Yes No

14. Lost or gained weight recently? Yes No. Experienced night sweats Yes No

15. Been out of the country Yes No. Lost bladder or bowel control Yes No

16. Had trouble with sexual function Yes No. Seen a primary care physician in last year Yes No

17. Since your problem began, the condition has? Increased Decreased Not Changed

18. Does your problem "flare up" and get worse at any point? _____

19. Are your complaints affecting your ability to work or otherwise be active? No effect on my activity level Some physical restrictions
 Need limited assistance with common everyday tasks Have a significant inability to function without assistance Totally disabled(impaired)
and cannot care for self

20. Does it interfere with your Work Sleep Daily Routine Recreation



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21. Type of complaint : Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____
22. What makes your problems Worse: Sitting Standing Walking Bending Lying Down
 Lifting Twisting Movement Rising from a chair
23. What makes your problems Better: Sitting Standing Walking Bending Lying Down
 Lifting Twisting Movement hot shower/hot pack
 cold pack rise from chair physical activity

24. When you wake up, the problem is BETTER WORSE NO CHANGE

25. As the day goes along the problem gets BETTER WORSE NO CHANGE

26. How often do you have this pain? Constant (76-100%) Frequent (51-75%) Occasional (26- 50%) Intermittent (25% or less)

27. Have you ever injured this area before? Yes No If yes, how many times have you experienced this problem? 1-4 5-8 >8

28. What treatment have you already received for your current condition?

- Medications Surgery Chiropractic Services Physical Therapy Other _____

29. Name, address, and telephone number of doctor(s)/healthcare providers who have treated you for this condition:

Dr. _____ Dr. _____ Dr. _____

 City State Zip City State Zip City State Zip

30. Current Medications, including vitamins, supplements, and over-the-counters

Medication Name	Reason	Medication Name	Reason
1) _____	_____	5) _____	_____
2) _____	_____	6) _____	_____
3) _____	_____	7) _____	_____
4) _____	_____	8) _____	_____

31. **Surgeries (Date & Reason):** (Please include all surgeries, especially spine procedures) _____

32. **Hospitalizations (Date & Reason)** _____

33. **Fractures/Dislocations/Falls/Car Accidents/Trauma:** _____

34. **Known Allergies** _____

35. Please circle all the conditions that you have currently or had previously.

- | | | | | |
|------------------------|----------------------|--------------------|-------------------------------|--------------------|
| Heart attack | Emphysema | Heart murmur | Angina | Asthma |
| High Blood Pressure | Anemia | Stroke/TIA | Bleeding disorder | Varicose Veins |
| Sexual difficulty | Stomach ulcer | Enlarged prostate | Duodenal problems | Menstrual problems |
| TB | Colon problems | Migraine Headaches | Diabetes | HIV/AIDS |
| Hepatitis | Scoliosis | Cirrhosis | Prosthetic joints/pins/screws | |
| Kidney stones | Kidney infection | Psoriasis | Depression | |
| Degenerative Arthritis | Rheumatoid Arthritis | Cancer type: _____ | | |

Exercise Activity



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36. Do you do any exercise on a regular basis? Yes No Days/Week _____

If yes, specify _____

37. Are you a member of a gym/fitness facility? Yes No

Which? _____

WORK ACTIVITY

Sitting Standing Light Labor Heavy Labor

HABITS

Smoking Packs/Week _____ If yes, last chest x-ray? _____

Smokeless Tobacco If yes, last dental visit _____ Used to smoke but quit How long Ago? _____

Alcohol Drinks/Week _____ Coffee/Caffeine Cups/Day _____

High Stress Level Reason _____

Female Health Questions

40. Do you have an OB/GYN Provider? If yes, who _____ Last visit _____

41. Are you pregnant? Yes No No Have you ever been pregnant? Yes No If yes, how many pregnancies _____

42. Complications during pregnancy/delivery? Yes No If yes describe _____

43. Children and age(s)? _____

44. Date of LMP _____ 45. Birth Control? Method _____

46. Have you ever had a PAP smear? Yes No If yes, approx. date _____

47. Have you ever had a mammogram? Yes No

48. Any history of breast, ovarian, cervical, uterine cancers/polyps/growths in you or family? Yes No

49. Ever had a routine or baseline EKG done? Yes No 50. CRP/Homocysteine levels? Yes No

51. Have you checked your Cholesterol levels? Yes No 52. Do you perform monthly breast self exams? Yes No

Male Health Questions

53. Have you ever had a digital prostate exam? Yes No 54. PSA Test? Blood test for prostate cancer Yes No

55. Do you perform testicular self exams? Yes No 55. Ever had a routine/baseline EKG done? Yes No

56. Checked Cholesterol level? Yes No 57. Checked CRP/Homocysteine levels? Yes No

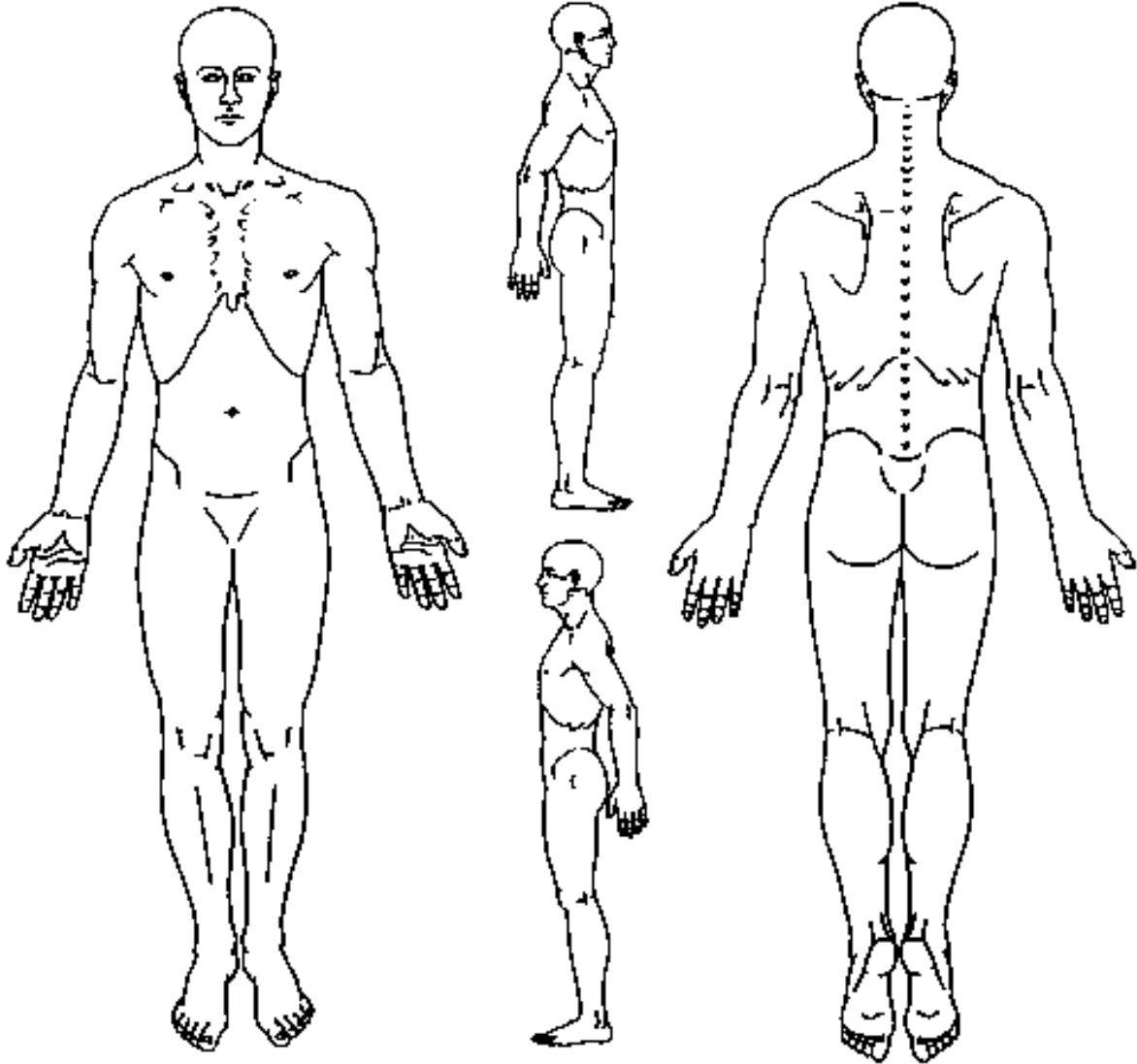
PLEASE FILL OUT PAIN DIAGRAM ON NEXT PAGE



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Pain Diagram



A = ACHE
S = STABBING

P = PINS & NEEDLES
N = NUMBNESS

B = BURNING
O = OTHER



0
NO
HURT



1
HURTS
LITTLE
BIT



2
HURTS
LITTLE
MORE



3
HURTS
EVEN
MORE



4
HURTS
WHOLE
LOT



5
HURTS
WORST