WELCOME TO HEMBREE CHIROPRACTIC

PERSONAL INFORMATION

Today's Date: ____/____/____ **Referred by:** _____

Patient Title: (check one) □ Mr. □ Mrs. □ Miss □ Dr. □ Prof. □ Rev.

First Name (legal name): _____ **Preferred Name:** _____

Last Name: _____ **Middle Name:** _____ **Suffix:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email: _____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Contact Method: (check one) □ Primary Phone □ Cell Phone □Work Phone □ Email

Check here to Opt Out of appointment reminders: □ Text □ Email

Birthdate: ____/____/____ **Age**_____ **Gender:** □ Male □ Female □ Unspecified

Marital Status (check one): □ Single □ Married □ Other **SSN:** _____/____/_____

Spouse Data: Is your spouse a patient of the clinic: □ Yes □ No **Spouse's Name:** _____

Emergency Contact: (Name, Relationship, Phone#) _____

Employment Status: □ Employed □ FT student □ Other □ Retired □ Self Employed

Name of Employer: _____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

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

Preferred Language: _____

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.

				Family History Mark **ALL** conditions that run in your family		Relationship: (Father,Mother,Sister,Brother)
□	Osteoarthritis/Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? □ Yes □ No □ Not Sure	□	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	□	Diabetes (check one) □Type I □ Type II	
□	Anemia	□	Migraines	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Osteoporosis /Osteopenia	□	High Blood Pressure	
□	Rheumatoid Arthritis	□	Epilepsy / Seizures	□	Genetic Disorders	
□	Depression/ Anxiety	□	Fibromyalgia / Chronic Fatigue	□	Rheumatoid Arthritis	
□	Disc Herniation	□	Genetic Disorders	□	Other (List):	
□	High Blood Pressure /Hypertension	□	Please list any other medical conditions:			
□	Heart Disease / Stroke					

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

SURGERIES and/or HOSPITALIZATIONS (List and Date):

Have you ever had an X-ray, CT scan or MRI of your spine? □ No □ Yes

If so, what facility performed the imaging and what location of your body was the imaging taken?

List current prescription medications, including frequency and dosage if known. **NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any know medical allergies (or life threatening allergies we should know about)

NO medication allergies, check here □

MEDICATION OR LIFE THREATENING ALLERGY	*ONSET DATE*	*REACTION/ADDITIONAL COMMENTS*

SOCIAL HISTORY

Do you exercise? □ Yes □No **Intensity?** □ Light □ Moderate □ Strenuous

Do you currently smoke tobacco of any kind? □ Yes □Former smoker □ Never been a smoker

Do you drink alcohol? □ Yes □No **How many drinks per week?**

Do you drink caffeine? □ Yes □No

Do you take pain medication □ Yes □No **How often?** □ Daily □Weekly □ Rarely □ Other:_____

Prescribing MD & Date?_____ **Prescription or OTC?**_____

What type? □ Aspirin □Ibuprofen □ Tylenol □ Anti-inflammatory □ Muscle Relaxers □ Other:_____

What do your work duties include? □ Sitting □Standing □ Light Labor □ Heavy Labor □ Other

Please describe your overall health right now? □ Excellent □ Very Good □ Good □ Fair □ Poor

What is your current stress level? ? □ Mild □ Moderate □ High

Have you seen a chiropractor in the past? □ Yes □ No

□ I choose to decline receipt of my clinical summary after every visit: *(These summaries are often blank as a result of the nature and frequency of chiropractic care)*

Patient Signature:_____ **Date:**_____

For office use only:

Height:_____ Weight:_____ Blood Pressure:_____/_____

REASON FOR VISIT

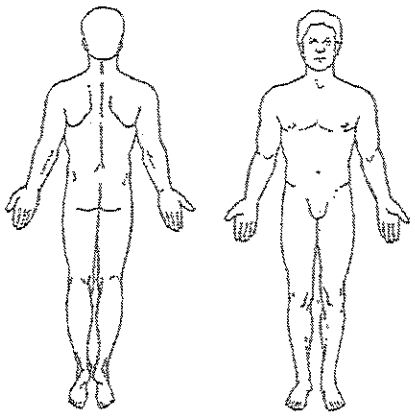
What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

What caused this complaint(s)?_____

When did this complaint begin? ____/____/____ **Is it getting worse?** □ Yes □ No □ Constant □ Comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when? _____

What does your complaint (s) feel like? **Circle all that apply**: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness /Other*_____



←**Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

What area(s) does the pain radiate, shoot, or travel to? (if applicable)?_____

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain ***Moderate Pain*** ***Worst Possible Pain***

0	1	2	3	4	5	6	7	8	9	10

What aggravates this complaint? **Circle all that apply**: Sitting / Standing / Walking / Getting up from seat / Walking stairs Sleeping / Physical Activity/ Movement / Bending forward / Bending backward / Twisting / Reaching /Lifting / Desk work / Everything

What relieves this complaint? Circle all that apply: Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching/ Massage / Chiropractic / Heat / Ice / Laying down / Medication / Nothing / Unknown / Other:_____

How often do you experience your symptoms? □ 25% of the day □ 50% of the day □ 75% of the day □ 100% of the day

Timing of complaint: **Check appropriate box:** □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change □ Other:_____

Have you seen other doctors for this complaint? □ Yes □ No If "Yes", please provide the following information:
Doctor's name:_____ Date consulted:_____Diagnosis:_____

Is this condition interfering with your: (Circle all that apply) Sleep / Getting in or out of bed or chair / Personal care / Travel /Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other:_____

Is your complaint interfering with your daily activities? □ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

List other musculoskeletal health complaints (2-5) on the following lines.

2._____ 4._____

3._____ 5._____

Patient Name:_____ **Date:**_____

Patient's Name: _____ Date: _____

Functional Rating Index

This form is required by insurance to determine the medical necessity of your care. Please circle the number which most closely describes your condition *right now*.

Pain Intensity

0. No pain
1. Mild pain
2. Moderate pain
3. Severe pain
4. Worst pain possible

Sleeping

0. Perfect sleep
1. Mildly disturbed sleep
2. Moderately disturbed sleep
3. Greatly disturbed sleep
4. Totally disturbed sleep

Personal Care (Washing/Dressing/Bending)

0. No pain or restrictions
1. Mild pain or restrictions
2. Moderate pain; need to go slowly
3. Moderate pain; needs some assistance
4. Severe pain; needs 100% assistance

Traveling (Driving, etc.)

0. No pain on long trips
1. Mild pain on long trips
2. Moderate pain on long trips
3. Moderate pain on short trips
4. Severe pain on short trips

Work

0. Can do usual work plus extra work
1. Can do usual work but no extra work
2. Can do 50% of usual work
3. Can do 25% of usual work
4. Cannot work

Recreation

0. Can do all activities
1. Can do most activities
2. Can do some activities
3. Can do a few activities
4. Cannot do any activities

Frequency of Pain

0. No pain
1. Occasional pain, 25% of the day
2. Intermittent pain, 50% of the day
3. Frequent pain, 75% of the day
4. Constant pain, 100% of the day

Lifting

0. No pain with heavy weight
1. Increased pain with heavy weight
2. Increased pain with moderate weight
3. Increased pain with light weight
4. Increased pain with any weight

Walking

0. No pain with any distance
1. Increased pain after 1 mile
2. Increased pain after ½ mile
3. Increased pain after ¼ mile
4. Increased pain with all walking

Standing

0. No pain after several hours
1. Increased pain after several hours
2. Increased pain after 1 hour
3. Increased pain after ½ hour
4. Increased pain with any standing

HEMBREE CHIROPRACTIC, PA

1904 West Grande Blvd. • Tyler, Texas

HIPAA
Notice of Privacy Practices

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (VERBAL AND COPY) TO MEMBER OF YOUR FAMILY OR OTHER INDIVIDUALS.

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of Hembree Chiropractic, PA to give copies and/or discuss your conditions/exams/procedures/x-rays with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, law stipulates these rules may be waived.

PLEASE CIRCLE:

I DO or **DO NOT (please circle one)** authorize Hembree Chiropractic, PA to leave a detailed message and/or confirm appointments on my HOME answering machine.

I DO or **DO NOT (please circle one)** authorize Hembree Chiropractic, PA to leave a detailed message and/or confirm appointments on my voice mail, cell number or email.

I DO or **DO NOT (please circle one)** authorize Hembree Chiropractic, PA to release any information concerning my care to my primary care physician or specialist.

(Other than parents/guardian of minor.)

I authorize Hembree Chiropractic, PA to release any information concerning my care to the person/s below:

Authorized Name (please print)	Relationship	Phone
Authorized Name (please print)	Relationship	Phone
Authorized Name (please print)	Relationship	Phone

Patient/Guarantor Signature _____ **Date** _____