WELCOME TO HEMBREE CHIROPRACTIC, PA

PERSONAL INFORMATION

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

Patient Title: (check one) ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.

Legal First Name: _____ **Preferred Name:** _____

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

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

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

Email: _____ **Check here to opt out of appointment reminders** ☐

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

Birthdate: _____ **Gender:** ☐ Male ☐ Female ☐ Unspecified **SSN:** _____

Marital Status (check one): ☐ Single ☐ Married ☐ Other

Emergency Contact:(Name, Relation & Phone#) _____

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

Name of Employer: _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Race: American Indian or Alaska Native/ Asian/ African American/White (Caucasian)/ Native Hawaiian or Pacific Islander/ I Decline to Answer **Preferred Language:** _____

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

SURGERIES, HOSPITALIZATIONS, TRAUMA, FRACTURES (List and Date):

_____

List current prescription medications, including dosage if known. **NO current medications, check here** ☐

1.	5.	9.
2.	6	10.
3.	7.	11.
4.	8.	12.

List any known medication allergies (or life-threatening allergies we should know about)

NO medication allergies, check here ☐

MEDICATION OR LIFE-THREATENING ALLERGY	*REACTION/ADDITIONAL COMMENTS*

For office use only:
Height: _____ Weight: _____ Blood Pressure: _____/_____

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 immediate family		
□	Osteoarthritis Degenerative Joint Disease	□	Whiplash Injury *Date of injury:*	□	Cancer *Type:*	
□	Asthma	□	Headaches	□	Anemia	
□	Diabetes □ Type I □ Type II	□	Heart Disease / Stroke	□	Diabetes □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	□		
□	High Blood Pressure Hypertension	□	Other (List):		Other (List):	

SOCIAL HISTORY

Do you exercise? □ Yes □No

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

Do you drink alcohol? □ Yes □No **Do you drink caffeine?** □ Yes □No

Do you take pain medication, if so how often? □ Daily □ Weekly □ Rarely □ Never

Prescription or OTC? _____

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

Primary Care Physician: _____

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

_____ (Initial) In the past 2 weeks, I have not experienced any COVID-19 related symptoms (such as: fever, shortness of breath, dry cough, sore throat, loss of taste or smell), tested positive to COVID-19, or been exposed to anyone who has tested positive to COVID-19.

Patient Signature: _____ **Date:**_____

To be completed by parent or guardian of a minor:
AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby grant my authorization and consent for any/all doctors of Hembree Chiropractic and whomever they designate as assistant to administer chiropractic care as deemed necessary to my _____ (indicate relationship pf child). I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of Hembree Chiropractic the exercise of his or her best judgement upon the advice of any such medical or emergency personnel.

☐ I authorize this minor to be brought to their appointment by someone other than the undersigned legal parent/guardian.

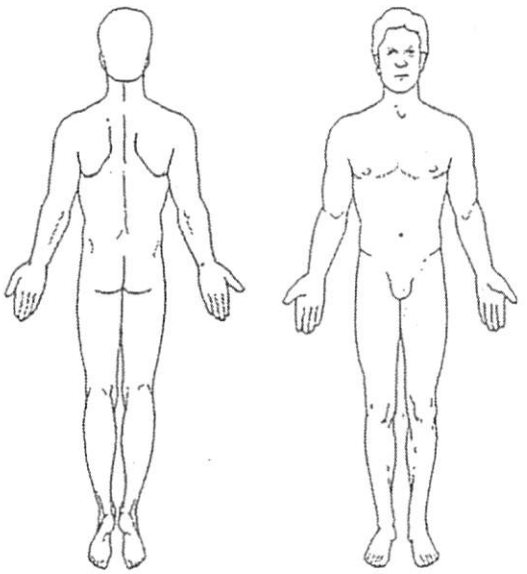
Parent/Legal Guardian Signature: _____

REASON FOR VISIT

What is the reason for your visit today? _____

What caused this complaint(s)? _____

Date complaint began _____



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

←**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) _____

On the scale below, please circle the severity of your main complaint at its worst:

No Pain				*Moderate Pain*					*Severe Pain*	
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Area for doctor's notes:

What aggravates this complaint? Circle all that apply: Sitting / Standing / Walking Getting up from seat / Walking up or down stairs / Sleeping / Physical Activity Bending / 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

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

Timing of complaint: □ Morning □ As day progresses □ Afternoon □ Evening □ While sleeping □ During activities □ After activities □ Symptoms are constant and do not change

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

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

List other musculoskeletal health complaints on the following lines.

_____

_____

Patient's Name: _____ Date: _____

Functional Rating Index

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

HIPAA Patient Consent Form

Hembree Chiropractic, PA
2004 W. Grande Blvd • Tyler, TX 75703

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. In order for your provider or the staff of Hembree Chiropractic to give copies and/or discuss your condition/treatment with members of your family or other individuals that you designate, we must obtain your authorization. In the event of a critical episode or if you are unable to give authorization due to the severity of your medical condition, law stipulates these rules may be waived.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

The practice reserves the right to change the privacy policy as allowed by law.

YES NO I authorize Hembree Chiropractic to phone, email, or send a text to confirm appointments?

YES NO I authorize Hembree Chiropractic to leave a message and/or confirm appointments on my answering machine at home or my voicemail on my cell phone?

YES NO I authorize Hembree Chiropractic to release any information concerning my care to my primary care physician or specialist

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

_____

_____

_____

This consent was signed by (PRINT NAME PLEASE): _____

Signature: _____ Date: _____