HUNGERFORD
CHIROPRACTIC & PHYSICAL THERAPY

NEW PATIENT INFORMATION SHEET

PATIENT

Last Name: _____ First Name: _____ Middle Initial: ____

Gender: M F Date of Birth: ___/___/___ Age: ___ SS#: _____ How many children?_____

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

Home Ph: (___)_____ Cell Ph: (___)_____ Work Ph: (___)_____

Employer Name: _____ Occupation: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____@_____

☐ If you would like to receive a text reminder for your appointment, please check here and complete the following:
Wireless provider_____ How far in advance to receive reminder? ___ 1hr ___ 4 hrs ___1 day

SPOUSE or GUARDIAN

Last Name: _____ First Name: _____ Middle Initial: ____

Employer Name: _____ Work Phone: _____

EMERGENCY *(Name and address of the nearest relative or friend not living with you)*

Last Name: _____ First Name: _____ Middle Initial: ____

Home Phone # (_____)_____ Work Phone # (_____)_____

Relationship to Patient: _____

INSURANCE

Your Insurance company may not pay for all charges, even some care that you or your healthcare provider has good reason to think you need. Hungerford Chiropractic & Physical Therapy will submit charges to your insurance company at your request, for an official decision on payment. I understand if my insurance company does not pay, I am responsible for payment._____.

Signature

RESPONSIBLE PARTY *(Complete this section if someone other than the patient is responsible for the bill.)*

Responsible Party: _____ Relationship to Patient: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone # (_____)_____ Work Phone # (_____)_____

Employer Name: _____ Occupation: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Is this condition due to an injury arising out of employment? Yes No

Is this condition due to an injury arising out of an auto accident? Yes No

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Health Questionnaire

Patient Name: _____ **Date:** _____

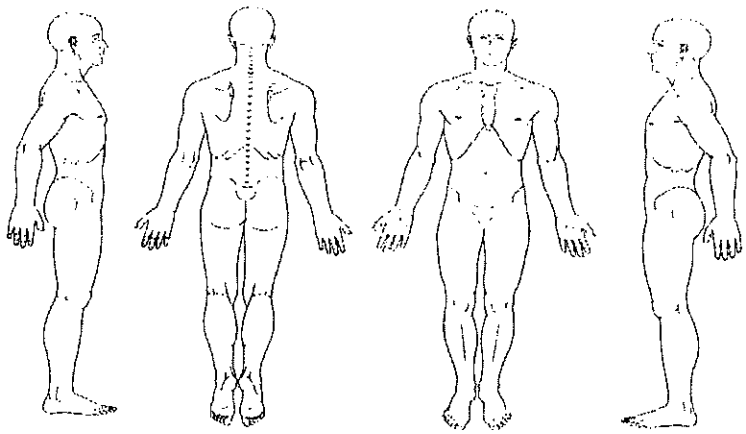
1. **Describe your symptoms and how they began:** _____

_____

2. **Have you ever received chiropractic treatment for any condition in the past?** Yes No

3. **When did your symptoms start?** _____

4. **Indicate below on diagram where you have pain or other symptoms:**



5. **How often do you experience your symptoms?**
   - ○ Constantly *(76-100% of the day)*
   - ○ Frequently *(51-75% of the day)*
   - ○ Occasionally *(26-50% of the day)*
   - ○ Intermittently *(0-25% of the day)*

6. **What describes the nature of your symptoms?**
   - ○ Sharp
   - ○ Dull Ache
   - ○ Numb
   - ○ Shooting
   - ○ Burning
   - ○ Tingling

7. **How are your symptoms changing?**
   - ○ Getting Better
   - ○ Not Changing
   - ○ Getting Worse

8. **How bad are your symptoms**

	No Pain										Unbearable
at their best:	0	1	2	3	4	5	6	7	8	9	10
	No Pain										**Unbearable**
at their worst:	0	1	2	3	4	5	6	7	8	9	10

Patient Health Questionnaire (cont.)

9. **What activities make your symptoms worse:** _____

10. **What activities make your symptoms better:** _____

11. **Who have you seen for your current symptoms?** _____

12. **Who is your primary medical physician?** _____

13. **Have you had similar symptoms in the past?** Yes No

    a. What tests have you had for your symptoms in the past?

    Xrays date: _____ MRI date: _____ CT Scan date: _____ Other date: _____

14. **What is your:** **Height:** _____ Feet _____ Inches **Weight:** _____ lbs.

15. **List all prescription/over-the-counter medications, and nutritional/herbal supplements you are taking:**

    _____

    _____

16. **List all the surgical procedures you have had and times you have been hospitalized:**

    _____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
○	○	Headaches	○	○	High Blood Pressure	○	○	Asthma
○	○	Neck Pain	○	○	Heart Attack	○	○	Chronic Sinusitis
○	○	Upper Back Pain	○	○	Chest Pains			
○	○	Mid Back Pain	○	○	Stroke	○	○	Smoking/Use Tobacco Products
○	○	Low Back Pain				○	○	Drug/Alcohol Dependence
			○	○	Kidney Stones			
○	○	Shoulder Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Elbow/Upper Arm Pain	○	○	Bladder Infection	○	○	Depression
○	○	Wrist Pain	○	○	Painful Urination			
○	○	Hand Pain	○	○	Loss of Bladder Control			***Females Only***
			○	○	Prostate Problems	○	○	Birth Control Pills
○	○	Hip/Upper Leg Pain				○	○	Hormonal Replacement
○	○	Knee/Lower Leg Pain	○	○	Abnormal Weight Gain/Loss	○	○	Pregnancy
○	○	Ankle/Foot Pain	○	○	Loss of Appetite	○	○	
○	○	Jaw Pain	○	○	Liver/Gall Bladder Disorder			***Other Health Problems/Issues***
○	○	Arthritis	○	○	Cancer	○	○	
○	○	Rheumatoid Arthritis	○	○	Tumor	○	○	
○	○	General Fatigue	○	○	Dizziness	○	○	

Patient Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

CONSENT TO USE & DISCLOSE HEALTH INFORMATION (2014)

18 Years of Age and Older

Hungerford Chiropractic and Physical Therapy

This office is required by Federal Regulations to inform our Patients in regards to the use of your child's health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

I understand that as part of my health care, Hungerford Chiropractic and Physical Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party can verify the services billed to me actually took place.

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. This notice is located in the waiting area in plain view. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered and the right to a paper copy of the Notice of Privacy Practices
- The right to object to the use of my health information for directory purposes
- The right to request special privacy protections
- The right to request confidential communications
- The right to inspect and copy
- The right to amend or supplement
- The right to an accounting of disclosures

I understand that Hungerford Chiropractic and Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat me as permitted by Federal Regulations.

I understand that Hungerford Chiropractic and Physical Therapy reserve the right to change their *Notice of Privacy Practices.*

I authorize the following individuals listed below access to my medical information from Hungerford Chiropractic and Physical Therapy or to discuss my medical information with Hungerford Chiropractic and Physical Therapy and its physicians (please print all names below).

Full Name	Relationship
Full Name	Relationship

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax. I further understand that I may revoke this consent at any time and I must notify Hungerford Chiropractic and Physical Therapy in writing in order to revoke the consent.

I fully understand and accept the terms of this consent.

Signature	**Date**
Print Name	**Date of Birth**

REVOKE CONSENT

(do not sign below unless you are revoking the above consent)

I hereby revoke the above consent effective immediately. I understand that revoking this consent means that my medical information and protected health information will no longer be discussed or disclosed (released) to the above individuals and that a new consent will need to be completed if this changes.

Signature of Patient	Date signed

Updated 5.20.14