HerringChiropractic

CASE HISTORY

Name: _____

Street/City/Zip: _____

Telephone: _____ **Cell Phone:** _____ **Email:** _____

Social Security # _____ **Age:**_____ **DOB:** _____ **Sex:** _____

Marital Status: _____ **Occupation**: _____ **Employer:** _____

Employer's Address: _____ **Phone:** _____

Spouse's Name: _____ **Referred By:** _____

What is your major complaint?_____

How long have you had this condition?_____

Other complaints: _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ___ Yes ___ No ___ Constant ___ Comes and goes

Is this condition interfering with your: Work __ Sleep __ Daily Routine __ Other: _____

List surgical operations: _____

Are you taking any medications? _____**What kind?** _____

Other doctors seen for this condition: _____

Doctor's Name: _____ **Diagnosis:** _____

X-Rays/MRI: _____ **Other:** _____

Treatment: _____

Were you off work? _____ **If so, how long?** _____

Have you returned to your same job? **If not, why?** _____

*****DID YOU HAVE A SPECIFIC ACCIDENT? (i.e. car accident, work injury, slip and fall)*****

Did your accident occur at work? _____ **Were you involved in an automobile accident?** _____

*** If you answered yes to either please let the staff know if you have not already done so***

By signing this form, you agree to allow us to bill your insurance if applicable.

Our office has a $25 now show/cancellation fee. If you need to cancel, we ask that you give us 24-hour notice to avoid the fee. By signing this form, you agree to this policy.

Patient's Signature _____ **Date:** _____

IMPORTANT: Please check (✔) all present symptoms. **NAME:**_____ **DATE:** _____

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears
- ☐ TMJ – Jaw pain

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS AND HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Arthritis in fingers
- ☐ Sensation of pins and needles in arms

ARMS AND HANDS (continued):
- ☐ Sensation of pins and needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Numbness in fingers (R-L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Loss of strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Irregular heartbeat
- ☐ Breast pain
- ☐ Dimpled or orange peel breast

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroiliac
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Pain relieves when _____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS, AND FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)

HIPS, LEGS, AND FEET (continued):
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R-L)
- ☐ Pins and needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)
- ☐ Pain in feet (R-L)
- ☐ Weakness in the leg (R-L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Menopause

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/ swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _____
- ☐ Loss of sleep _____ hrs./ night
- ☐ Loss of weight _____ lbs.
- ☐ Weight gain _____ lbs.
- ☐ Coffee _____ cups/ day
- ☐ Tea _____ cups/ day
- ☐ Cigarettes ____pack/ day
- ☐ Other _____
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS:

_____

_____

_____

_____

HerringChiropractic

WORK COMP QUESTIONAIRE

Name: _____ **Date of Accident:** _____

1. Name of employer at the time of accident: _____
2. Length of time worked there prior to accident: _____
3. Type of work being done at the time of injury: _____
   _____
4. In your own words, please describe the accident: _____
   _____
   _____
5. Have you been treated by another doctor for this accident? ☐ Yes ☐ No
   If yes, please list doctors names and phone numbers: _____
   _____
6. Are you: ☐ Improved ☐ Unchanged ☐ Getting worse
7. What medications are you taking? _____
   _____
8. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
   ☐ Yes ☐ No ☐ Don't know
   If yes, describe: _____
   _____
   Were these similar complaints the result(s) of a previous accident(s)? ☐ Yes ☐ No
   If yes, describe details of accident(s): _____
   _____
9. Have you had any other serious accident which require medical care? ☐ Yes ☐ No
   If yes, describe: _____
10. Have you had any injury of illness that requires hospitalization? ☐ Yes ☐ No
    If yes, describe: _____
11. Have you had any surgeries? ☐ Yes ☐ No
    If yes, describe: _____
12. Have you had any nervous or mental Illness? ☐ Yes ☐ No
13. Have you had psychiatric care? ☐ Yes ☐ No
14. Have you received a medical discharge from the Armed Forces? ☐ Yes ☐ No
15. Have you returned to work since the accident? ☐ Yes ☐ No
    If you have returned to work fill out the info below:
    Date: _____ Employer: _____ Occupation: _____
    Light duty, regular duty? _____ Full time, part time? _____

OTHER PAIN:

Please describe any current medical complains which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____
_____
_____

JOB DESCRIPTION:

1. **In a typical 8 hour workday, circle # of hours of each activity:**

Sit:	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	hours
Stand:	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	hours
Walk:	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	hours

2. **On the job, I perform the following activities:**

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐

3. **On the job, I lift:**

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	☐	☐	☐	☐
11-24 pounds	☐	☐	☐	☐
25-34 pounds	☐	☐	☐	☐
35-50 pounds	☐	☐	☐	☐
51-74 pounds	☐	☐	☐	☐
75-100 pounds	☐	☐	☐	☐

4. **Do you have to bend over while doing any lifting?** ☐ Yes ☐ No
5. **Are your feet used for repetitive movements, such as operating foot controls?** ☐ Yes ☐ No
6. **Do you use your hands for repetitive actions, such as?**

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. Are you required to work on unprotected heights? ☐ Yes ☐ No
8. Are you required to be around moving machinery? ☐ Yes ☐ No
9. Are you exposed to making changes in temperature and humidity? ☐ Yes ☐ No
10. Are you required to drive automotive equipment? ☐ Yes ☐ No
11. Are you exposed to dust, fumes, and/or glass? ☐ Yes ☐ No
12. Please list any additional comments: _____

_____

_____

_____ _____

Patient Signature **Date**

PERCEPTION OF PAIN FINDINGS

Name: _____ **Date of Accident:** _____ **Date of Exam:** _____

GRADE LEVEL OF PAINS FROM 1 TO 10

	No pain	**1-2** *Mild*	**3-4**	**5-6** *Moderate*	**7-8**	**9-10** *Severe*
Headaches	☐	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐	☐
Jaw Pain – Right	☐	☐	☐	☐	☐	☐
Jaw Pain – Left	☐	☐	☐	☐	☐	☐
Shoulder Joint - Right	☐	☐	☐	☐	☐	☐
Shoulder Joint - Left	☐	☐	☐	☐	☐	☐
Arm - Right	☐	☐	☐	☐	☐	☐
Arm - Left	☐	☐	☐	☐	☐	☐
Elbow Joint - Right	☐	☐	☐	☐	☐	☐
Elbow Joint - Left	☐	☐	☐	☐	☐	☐
Wrist – Right	☐	☐	☐	☐	☐	☐
Wrist – Left	☐	☐	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐	☐	☐
Upper Back - Right	☐	☐	☐	☐	☐	☐
Upper Back - Left	☐	☐	☐	☐	☐	☐
Mid Back - Right	☐	☐	☐	☐	☐	☐
Mid Back – Left	☐	☐	☐	☐	☐	☐
Lower Back – Right	☐	☐	☐	☐	☐	☐
Lower Back – Left	☐	☐	☐	☐	☐	☐
Hip - Right	☐	☐	☐	☐	☐	☐
Hip - Left	☐	☐	☐	☐	☐	☐
Leg - Right	☐	☐	☐	☐	☐	☐
Leg - Left	☐	☐	☐	☐	☐	☐
Knee - Right	☐	☐	☐	☐	☐	☐
Knee - Left	☐	☐	☐	☐	☐	☐
Ankle – Right	☐	☐	☐	☐	☐	☐
Ankle – Left	☐	☐	☐	☐	☐	☐

SIGNATURE _____

NAME: _____ ***DATE*:** _____

YOUR PAIN: Below are several areas in which we would like you to indicate where you have pain, and how it feels.

HEADACHES:

The FREQUENCY is: →	☐ Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐ Other	
The SEVERITY is: →	☐ Mild	☐ Slight	☐ Moderate	☐ Severe	
The QUALITY is: →	☐ Dull/ Aching	☐ Sharp/ Stabbing	☐ Burning	☐ Throbbing	
The Pain RADIATES: →	☐ Down Left Arm	☐ Down Right Arm	☐ Down Both Arms	How far down?	_____

NECK PAIN:

The FREQUENCY is: →	☐ Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐ Other	
The SEVERITY is: →	☐ Mild	☐ Slight	☐ Moderate	☐ Severe	
The QUALITY is: →	☐ Dull/Aching	☐ Sharp/ Stabbing	☐ Burning	☐ Throbbing	
The PAIN is: →	☐ On the Left Side	☐ On the Right Side	☐ Both Sides	☐ More on one side	
The Pain RADIATES: →	☐ Down Left Arm	☐ Down Right Arm	☐ Down Both Arms	How far down?	_____

MID BACK PAIN:

The FREQUENCY is: →	☐ Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐ Other	
The SEVERITY is: →	☐ Mild	☐ Slight	☐ Moderate	☐ Severe	
The QUALITY is: →	☐ Dull/ Aching	☐ Sharp/ Stabbing	☐ Burning	☐ Throbbing	
The PAIN is: →	☐ On the Left Side	☐ On the Right Side	☐ Both Sides	☐ More on one side	
The Pain RADIATES: →	☐ Down Left Side	☐ Down Right Side	☐ Down Both Sides		

LOW BACK PAIN:

The FREQUENCY is: →	☐ Constant (100%)	☐ Intermittent (50%)	☐ Occasional (25%)	☐ Other	
The SEVERITY is: →	☐ Mild	☐ Slight	☐ Moderate	☐ Severe	
The QUALITY is: →	☐ Dull/ Aching	☐ Sharp/ Stabbing	☐ Burning	☐ Throbbing	
The PAIN is: →	☐ On the Left Side	☐ On the Right Side	☐ Both Sides	☐ More on one side	
The Pain RADIATES: →	☐ Down Left Leg	☐ Down Right Leg	☐ Down Both Legs		

OTHER AREAS: Please describe and list any additional areas of pain you may be experiencing (Arms, Legs, Feet, Ribs, Knees, etc.) using the same descriptions from above.

	Frequency	**Severity**	**Quality**	**Pain**
Other: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

Back Index

Form BI100

Patient Name _____ ***Date*** _____

This questionnaire will give your provider 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 The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

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.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

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.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

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 affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Neck Index

Form N1-100

Patient Name _____ ***Date*** _____

This questionnaire will give your provider 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 very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

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).

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 can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

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 concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
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.
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.

Personal Care

⓪ I can look after myself normally 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 manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, 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.

Driving

⓪ I can drive my car without any 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.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

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.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

HerringChiropractic

Informed Consent to Chiropractic Treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first days of treatment.

2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature **Print Name**

_____ _____

Date **Witness Signature (to be signed by office)**

HerringChiropractic

Name: _____ **Date:** _____

Psychological Symptoms Questionnaire

Have you experienced any of the following related to your injury?

Tension…….	☐ Yes	☐ No
Sleeplessness……	☐ Yes	☐ No
Anxiety……	☐ Yes	☐ No
Depression……..	☐ Yes	☐ No
Tired/Fatigue……..	☐ Yes	☐ No
Feeling of helplessness……..	☐ Yes	☐ No
Nervous……..	☐ Yes	☐ No
Worry about future……	☐ Yes	☐ No
Verbal abuse at work…….	☐ Yes	☐ No
Harassment by supervisor/coworkers…	☐ Yes	☐ No
Thoughts of suicide……	☐ Yes	☐ No
Fears of death or dying……..	☐ Yes	☐ No
Thoughts of homicide……	☐ Yes	☐ No
Confused thoughts…….	☐ Yes	☐ No
Poor concentration…….	☐ Yes	☐ No
Anger/Frustration……...	☐ Yes	☐ No
Crying spells……..	☐ Yes	☐ No
Mood changes……	☐ Yes	☐ No
Poor self-esteem…….	☐ Yes	☐ No
Irritability……	☐ Yes	☐ No
Withdrawal from family/friends…….	☐ Yes	☐ No
Feelings of discrimination……..	☐ Yes	☐ No
Self-doubt……	☐ Yes	☐ No

_____

Signature

HerringChiropractic

Patient Name: _____ Date: _____

List the names, addresses, and phone numbers of any DOCTORS and/or HOSPITALS you have been to for these symptoms.

Doctors/Hospital Seen for Current Symptoms:

(Example - ER, primary doctor, etc.)

Name_____

Address: _____

Phone Number: _____

Date of Treatment: _____

****

Name_____

Address: _____

Phone Number: _____

Date of Treatment: _____

****

Name_____

Address: _____

Phone Number: _____

Date of Treatment: _____

HerringChiropractic

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ **Date of Request:** _____

As required by the Privacy Regulations, The Doctors Office may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

HERRING CHIROPRACTIC

15817 Bernardo Center Dr. #105

San Diego, CA 92127

(858) 674-7200

Patient Health Information authorized to be disclosed: (please circle below)

Doctors Reports ☐ **MRI Reports** ☐ **X-Rays** ☐ **Chart Notes** ☐ **All Medical Records** ☐

Other _____

Effective dates for this authorization: _____ through _____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:
1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment. enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient **Date**

_____ _____

Authorized Signature of Facility **Date**

Privacy Notice

I have received the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide the Doctors Office with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient name (Print)

_____ _____

Patient Signature **Date**

_____ _____

Authorized Facility Signature **Date**

If you would like a copy of the privacy notice for your records, please let the front desk staff know.

Our privacy notice is also available on our website.