HARVILLE CHIROPRACTIC

Today's Date: ___/___/___ Date of Injury (if applicable) : ____/___/_____
First Name: _____ Middle Initial: _____ Last Name: _____
What you prefer to be called: _____
Birthdate: ___ /___ /____ Age: _____ Social Security #:_____-____-_____
Male☆ Female☆ Are you: Single / Married /Separated / Widowed
Street Address:_____ City:_____ State: ____ Zip:_____
Cell Phone #: ( )_____ Work #: ( )_____ Home #: ( )_____
Would you like to be signed up for our automatic appointment text alerts? Yes No
If 'Yes', what is your cell phone provider? : Sprint / Verizon / ATT / T-Mobile / Other: _____
Email Address: _____ Referred to us by: _____
Employer: _____ Occupation: _____
Employer's Address:_____ City:_____ State: ____ Zip: _____

In Event of Emergency, contact: _____ Relation:_____
Cell Phone #: _____ Work #:_____

Primary Care Physician: _____ Practice Name: _____ City: _____
Do you give Harville Chiropractic permission to share your health info with the above doctor? Y or N
Patient's Signature (to release records): _____

*X-Ray Consent for Women of Childbearing Age *(10-55 years)*

X-ray examinations of abdomen and pelvis exposing the uterus to radiation are the following:
1) Abdomen (KUB) 2) Hips 3) Sacrum 4) Coccyx 5) Spines 6) Pelvis
The 10 days following onset of menstrual period are generally considered safe for x-ray examinations.
Onset of last menstrual period, Date:___/___/____ Today's Date: ___/____/____
I am pregnant: Yes / No / I don't know *** I have had a hysterectomy: Yes / No
I use an IUD (Intrauterine device): Yes / No *** I have had a tubal ligation: Yes / No

I recognize that I'm pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to me health. I therefore wish to have this examination performed now.

Patient's Signature: _____ Witness:_____
I decline the doctor's recommendations of an x-ray examination.
Patient's Signature: _____ Witness:_____

3967 Presidential Parkway, Suite B / Powell, OH
P: 614.791.0663 / F: 614.791.8199

HARVILLE CHIROPRACTIC

CONSULTATION- *Condition Centered*

Name: _____ Today's Date: _____

Please list complaint(s)	List Onset Date(s)
1.	
2.	
3.	
4.	

What do you think caused your chief complaint_____
What do you think it going on? _____
What makes it worse? _____
What makes it better? _____
How long does it last? _____
Is it getting worse? _____
Have you had similar complaints before? _____
Quality of complaint (circle): Sharp Dull Burning Numbness Pins & Needles Aching
Does it radiate? _____
Are you concerned about it getting worse ? _____
Do you have any other concerns? _____
What do you hope to achieve in our office? _____
How long are you expecting that will take?
Are you wanting to just patch this condition up or achieve more of a permanent solution if possible?
_____

SUBLAXATION CASE HISTORY

Physical Stress:
1. _____ 2. _____ 3. _____
Chemical Stress:
1. _____ 2. _____ 3. _____
Emotional Stress:
1. _____ 2. _____ 3. _____

WELLNESS CHIROPRACTIC

Have you've ever seen a Wellness Chiropractor before? _____
If so, what was your experience?_____
Do you have any concerns about seeing a chiropractor? _____
Notes: _____
_____
_____

THIS IS A CONFIDENTIAL HEALTH REPORT

NAME _____ Date _____
(last) (first) (middle)

HEIGHT _____ WEIGHT _____

CHILDREN (list ages & sex) _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT

OCCASIONAL / FREQUENT

GENERAL
- Allergy (list below)*
- Convulsions
- Dizziness or fainting
- Headache
- Neuralgia
- Numbness

MUSCLE
- Arthritis
- Bursitis
- Foot trouble
- Low back pain or stiffness
- Pain between shoulders
- Sciatica
- Swollen joints

Pain, numbness or Cramps
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet

GASTRO-INTESTINAL
- Colon trouble
- Constipation
- Diarrhea
- Difficult digesting
- Gall bladder trouble
- Hemorrhoids
- Liver trouble
- Pain over stomach

EYES, EARS, NOSE & THROAT
- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Ear noise
- Eye pain
- Nasal obstruction
- Sinus infection

CARDIO-VASCULAR
- Hardening of the arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Swelling of ankles

RESPIRATORY
- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN
- Bruise easily
- Dryness
- Skin eruptions (rash)
- Varicose veins

GENITO-URINARY
- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine

FOR WOMEN ONLY
- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Menopausal symptoms
- Painful menstration
- Vaginal discharge

Pregnant ☐Yes ☐No
Date of last period _____
Previous miscarriages ☐Yes ☐No

DATE OF LAST: (Approx.)
- _____ Physical examination
- _____ Blood test
- _____ Chest x-ray
- _____ Spinal x-ray
- _____ Dental x-ray
- _____ Urine test

	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries- _____

_____

_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Pacemaker	☐ Stroke	

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name _____ Date _____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE

CASE HISTORY

NECK PAIN DISABILITY INDEX

HARVILLE CHIROPRACTIC

Patient Name: _____ Date:_____

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please circle only the one choice which closely describes your NECK problem.

SECTION 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I cannot lift or carry anything at all.

SECTION 4 –Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I wanted because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – Headache

A. I have no headaches at all.
B. I have slight headaches which come in-frequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all of the time.

DISABILITY INDEX SCORE: %_____

SECTION 6- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 – Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than I hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 – Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am to engage in most, but not all recreational activities because of pain in my neck.
D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

LOWER BACK DISABILITY INDEX

HARVILLE CHIROPRACTIC

Patient Name: _____ Date:_____

This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please circle only the one choice which closely describes your LOWER BACK problem.

SECTION 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 –Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than ½ mile.
E. I can only walk while using a cane or on crutches
F. I am in bed most of the time and have to crawl to the toilet

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour
E. Pain prevents me from sitting more than 10 min.
F. Pain prevents me from sitting at all.

SECTION 6- Standing

A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for longer than ½ hour without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7 – Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping
C. Because of pain, my normal night's sleep is reduced by less than one quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often
E. Pain has restricted my social life to my home.
F. Pain prevents me from sleeping at all.

SECTION 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but one of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it doesn't compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that's done lying down.

SECTION 10 – Changing Degree of Pain

A. My pain is rapidly getting better
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse,
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %_____

Assignments of Proceeds, Contractual Lien, and Authorization "Agreement"

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, individual, and other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to and exclusively in the name of Harville Chiropractic Center, Inc. (abbreviated name HCC) such sums as may be owing to HCC to claim protection under the statutory lien law. For the purposes of this agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgement or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical and underinsured motorists coverage, third party liability distributions, malpractice proceeds, attorney retainer agreements and any other benefits or proceeds payable to me for the purposes stated herein, regardless pf whether such proceeds are related to me charges or not.

I further that in the event a payer refuses to pay HCC, I hereby assign, in so far as permitted by law, all of my rights, remedies, and benefits to HCC to the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in the Office's name and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon insurance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to me accident, to promptly pay such office, and to provide a full accounting of such funds to the office upon its request. I direct all payers to release to HCC any information regarding any coverage or benefits which I may have including, but now limited to, the amount of the coverage, the amount paid this far, and the amount of any outstanding claims.

I authorize this office to release any information regarding treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this agreement. I hereby direct this office to file a copy of this agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize HCC to endorse/sign my name on any and all checks listing me as payee which are presented to this office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize HCC to apply any credit balances on charges uncured by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to HCC for their services. This agreement does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse HCC fort all costs of such collection efforts, including but not limited to, all court costs and all attorney fees.

This agreement shall not be modified or revoked without the mutual written consent of HCC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations shall conflict with the terms of this agreement.

I agree that each and every provision of this agreement is reasonably necessary for the protection of the rights and interest of HCC and myself. However, should any provision of this agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party thereto, all other portions and provisions of this agreement shall, nevertheless, remain in full force and effect.

Patient Name (Please Print)_____

Patient Signature_____Date_____

Name of Custodial Parent or Legal Guardian (Please Print)_____

Parents/ Guardian's Signature_____Date_____