HAMBY CHIROPRACTIC & WELLNESS

Patient Application

Full Name: _____ Date: _____

Address: _____ City: _____ State: ____Zip: _____

Cell Ph: _____ Work / Other Ph: _____ Email: _____

Gender: M F Age: ____ Birth Date:_____ SSN#: _____ Marital Status: S M D W

Occupation: _____ Employer: _____

Spouse Name: _____ Ph: _____

How did you hear about us? _____

CHIROPRACTIC EXPERIENCE

Have you seen a Chiropractor before? **YES** **NO** When? _____

Reason for previous chiropractic care? _____

Have you had X-rays, MRI, CT-Scan? **YES** **NO** Where? _____

PURPOSE FOR THIS VISIT

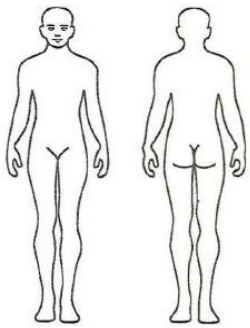
Are your present problems due to an injury? YES NO Enter the date of the injury: _____

Was the injury ☐ Job Related ☐ Auto Accident ☐ Personal Injury ☐ Other: _____

Please list the **reasons** for the visit along with their **levels of severity:**

1. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
2. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
3. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe
4. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Please **circle areas on the diagram** below where you have pain or other symptoms:



HEALTH GOALS

When do you expect to get relief? _____

When do you expect complete resolution/results? _____

What do you think would happen with your condition if you do nothing? _____

_____

FOR OFFICE USE ONLY

Account # _____ 1 2 ☐ Acct/Folder ☐ WellScore ☐ Cond/Diag ☐ Ins/Bill ☐ ROF ☐ Scanned

HEALTH CONDITIONS

Cervical Spine (Neck): Are you experiencing any of the following symptoms?

__Neck pain __Headaches __Sinusitis __Dizziness __Allergies __Fatigue __Loss of balance __Neck stiffness __Tension

__Pain in shoulders/arms/hands __Numbness tingling arms/hands __Weakness in grip __ Low energy __Trouble Sleeping

Thoracic Spine (Upper Back): Are you experiencing any of the following symptoms?

__Upper back pain __Pain on deep inhaling/exhaling __Shortness of breath __Asthma/Wheezing

__Chest pain __ Pain between shoulders

Thoracic Spine (Mid Back): Are you experiencing any of the symptoms?

__Mid back pain __Pain into your ribs/chests __ Stomach issues __Indigestion/Heartburn __Shortness of Breath

Lumbar Spine (Low Back): Are you experiencing any of the following symptoms?

__Low back pain __Pain in your hips/legs/feet __Numbness/tingling in legs/feet

__Muscle cramps legs/feet __Weakness/injuries in your hips/knees/ankles

SYMPTOM DETAILS

1. When did you first notice your symptoms: _____
2. Is this condition getting __ better __worse __staying the same?
3. Is this condition __ Constant __Comes & Goes __Activity Related
4. Does it interfere with __Work __Sleep __Exercise __Hobbies __Daily Routine __Self-Care
   Other: _____
5. What activities aggravate your symptoms? _____
6. Is there anything that relieves your symptoms? **YES** **NO** Explain: _____
   _____
7. Have you experienced this condition before? **YES** **NO** Explain: _____
   _____
8. Have you seen anyone for this condition? **YES** **NO** If so, what did they do? _____
   _____
9. Are you aware that poor posture has a negative impact on your health? **YES** **NO**
10. Have you noticed that you carry your head forward or that your shoulders are rounding? **YES** **NO**
11. Are you aware of any poor posture habits you may have? **YES** **NO**
12. Do you exercise? ☐ None ☐ Light ☐ Moderate ☐ Daily
13. Please list any health conditions not mentioned: _____
    _____
    _____
14. Please list any medications, supplements (i.e. vitamins, minerals, herbs), and surgeries:
    _____
    _____
    _____

Signature of Patient / Guardian: _____ Date: _____

Emergency Contact: _____ Relationship: _____ Ph: _____

Oswestry Low Back Disability Questionnaire

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 effect 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.

For Doctor's Use:

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

Back Index Score ☐

Oswestry Neck Disability Questionnaire

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.

For Doctor's Use:

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

Neck Index Score ☐

HAMBY CHIROPRACTIC & WELLNESS

TERMS OF ACCEPTANCE

Patient Name: _____ **Date:** _____/_____/_____

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. **I understand that if I am accepted as a patient at Hamby Chiropractic & Wellness, Ltd.,** I am authorizing them to proceed with any treatment that the doctor deems necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Authorization of Care

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments, modalities, and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this office. I also understand that if I do not follow the doctor's specific recommendations that I will not receive the full benefit from the recommended care programs.

Consent to Evaluate and Treat a Minor:

I have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X-Ray Permission:

PLEASE CHECK ONE: I, ☐ **give** or ☐ **do not** give permission to x-rays for diagnostic interpretation.

Missed Appointments:

We are committed to providing each patient with exceptional care. When a patient cancels without giving adequate notice, they prevent another patient from receiving the same exceptional care. **Please contact our office at (912) 826-4444 within 24 hours prior to your scheduled appointment. If prior notification is not given, a $30 fee may be charged.**

I have read and fully understand all the above statements.

Signature of Patient/Legal Guardian: _____ **Date:** ____/____/____

Acknowledgement

We are very concerned with protecting the privacy of your health information. There are several circumstances in which we may have to use or disclose your health information. We may disclose your health information to another healthcare provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of services. I understand I will be given a complete copy of the notice of privacy practices (HIPAA) upon request.

Payment

I understand that payment is due at the time of service. If any balance is left on my account, I authorize Hamby Chiropractic & Wellness to charge any form of payment that I may have on file (encrypted) for services rendered.

Communications:

I understand that disclosure may be made to family/friends regarding my health or as needed for payment of health care services. That information will only be disclosed relevant to current treatment. I give my permission for my health care information to be disclosed to the following people:

Family Member/Friend	Relationship	Phone Number

Legal Assignment of Insurance Benefits and Release of Medical Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage, and hereby assign and convey directly to **Hamby Chiropractic & Wellness, Ltd**. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such provider and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between the carrier and myself. I understand that insurance carriers may deny my claims and that I am ultimately responsible for all unpaid balances.

This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand all the above statements.

Signature Patient/Legal Guardian: _____ **Date:** ____/____/____