NEW PATIENT INTRODUCTION

(please print clearly)

Today's Date_____

Name_____Age_____Date of Birth____/____/____

Address_____City_____State_____Zip_____

Home #_____Work #_____Cell #_____ ❑ Single ❑ Married

Occupation_____Employer_____

Referred by_____Previous Chiropractic Care (yes) (no)

Where_____When_____

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED
UNLESS OTHERWISE ARRANGED

CONFIDENTIAL PATIENT INFORMATION

Huskey Chiropractic
Dr. Rick Huskey • Dr. Chandler Huskey
3820 E. 51st, Suite A
Tulsa, OK 74135
(918) 747-0939

DATE _____

If your injuries are due to an auto accident or work related accident please see front desk for appropriate paperwork.

NAME:_____ SS#:_____
LAST FIRST MI

ADDRESS:_____HOME PHONE:_____

CITY:_____ STATE:_____ ZIP:_____CELL PHONE:_____

BIRTHDATE:_____ EMAIL:_____

( )MALE ( )FEMALE ( )SINGLE ( )MARRIED ( )DIVORCED ( )WIDOWED

EMPLOYER:_____PHONE:_____

SPOUSE'S NAME:_____ DOB:_____SPOUSE'S SS#:_____

SPOUSE'S EMPLOYER:_____ EMPLOYER PHONE:_____

EMERGENCY CONTACT:_____ PHONE:_____

Due to HIPPA regulations we will not discuss financial or medical records with anyone but our patient. If you would like to give our office authorization to discuss financial and/or medical records with your spouse or any other party please list their name and relation:_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

NAME OF PRIMARY CARE PHYSICIAN:_____ PHONE:_____

Routine correspondence concerning your condition is sent to your PCP unless you advise otherwise.

PERSONAL HEALTH INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO.:_____ ID#:_____

EMPLOYER:_____ GROUP#:_____

PRIMARY INSURED NAME:_____ SS#:_____ DOB:_____

ARE YOU REQUIRED TO HAVE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN? YES ___ NO ___

NAME OF SECONDARY INSURANCE CO.:_____ ID#:_____

EMPLOYER:_____ GROUP#:_____

PRIMARY INSURED NAME:_____ SS#:_____ DOB:_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient / Guardian Signature: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patient / Guardian Signature: _____

(over)

1. Please describe your area(s) of complaint. _____

_____

_____

2. How did this condition develop? (What caused it?) _____

_____

_____

3. On what date did your condition begin? _____

4. Have you ever had this problem or similar problems before? ❑ Yes ❑ No If yes, please explain: ___

_____

What activities make your condition/s feel better? _____

What activities make your condition/s feel worse? _____

What activities do you find difficult to do because of this problem? _____

_____

Describe your pain: ( ) Sharp ( ) Dull ( ) Burning ( ) Ache ( ) Shooting ( ) Deep & Boring

Frequency of your pain: ( ) Occasional 0-25% ( ) Intermittent 26-50% ( ) Frequent 51-75% ( ) Constant 76-100%

Is your pain better in ( ) a.m. or ( ) p.m.?

Are your symptoms: ( ) Getting better ( ) Getting worse ( ) Staying the same

Have you taken medication for this current condition? Yes ___ No ___ Rx _____

Does your problem wake you from a sound sleep? Yes ___ No ___

Do you have numbness or tingling? Yes ___ No ___ Where _____

Does your problem get worse while lying down? Yes ___ No ___

Do you have loss of bladder control? Yes ___ No ___

Have you recently had fever, sweats or chills? Yes ___ No ___

Do you have diabetes? Yes ___ No ___

Do you have a thyroid problem? Yes ___ No ___

Do you suffer from depression? Yes ___ No ___

Do you have dizziness? Yes ___ No ___

Do you have heartburn/indigestion? Yes ___ No ___

Do you have high blood pressure? Yes ___ No ___

Do you have painful urination? Yes ___ No ___

Have you been diagnosed with rheumatoid arthritis? Yes ___ No ___

Do you have noises in your ears? Yes ___ No ___

Do you have blurred or double vision? Yes ___ No ___

ARE YOU PREGNANT?
❑ YES ❑ NO

HAVE YOU SEEN ANOTHER CHIROPRACTOR
❑ YES ❑ NO

If yes, Whom? _____

When? _____

PLEASE CHECK (✔) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

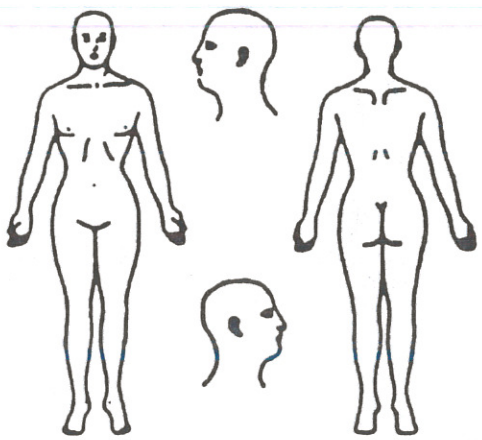
NERVOUS SYSTEM

- ❑ Numbness
- ❑ Loss/Increased sensation
- ❑ Paralysis
- ❑ Dizziness
- ❑ Fainting
- ❑ Headaches
- ❑ Muscles jerking
- ❑ Convulsions
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression
- ❑ Insomnia

MUSCULO-SKELETAL SYSTEM

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Pain between shoulders
- ❑ Neck pain
- ❑ Disc problems
- ❑ Arm problems
- ❑ Leg problems
- ❑ Swollen joints
- ❑ Stiff & painful joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Muscle spasms

Please mark areas of pain on the figures below.



P ___ Pain C ___ Cold Sensation

N ___ Numb S ___ Spasm

HOW BAD IS THE PAIN

None 1 2 3 4 5 6 7 8 9 10 Severe

Name _____ Date _____

Ethnicity _____ Hispanic/Latino _____ Non-Hispanic/Non-Latino

Race: _____ American Indian _____ Alaskan Native _____ Asian _____ African American/Black

_____ Native Hawaiian _____ Caucasian/White

Smoking Status: _____ Yes _____ No Frequency _____ Quit?/When
__/__/__

No known Drug Allergies or List Allergies : _____

_____

_____

No Medications or List of Medications : _____

_____

_____

_____

Family History and indicate the relationship:	Father	Mother	Sister	Brother
Anxiety _____				
High Blood Pressure _____				
Cancer/What Kind _____				
Depression _____				
COPD _____				
Heart Disease/Attack _____				
Diabetes _____				
Headaches/Migraines _____				
Arthritis _____				
Scoliosis _____				

Huskey Chiropractic
Dr. Rick Huskey * Dr. Chandler Huskey

3820 E. 51st St., Suite A
Tulsa, OK 74135

Notice of Receipt of Privacy Notice of Huskey Chiropractic

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Huskey Chiropractic Clinic, in force as of April 14, 2003 and that all of my questions have been answered to my satisfaction in language that I can understand.

Print Name of Individual

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Relationship

Date Signed: _____

Witness: _____