HUG Chiropractic Clinic
We get to the core of the problem

3153 Cahaba Heights Rd.
Birmingham, AL 35243
205-967-0280
www.birminghamchiropractor.net

CONFIDENTIAL PATIENT INTAKE FORM

NAME:_____AGE:_____DOB:_____SS#_____

HOME ADDRESS:_____CITY:_____ST:_____ZIP_____

EMPLOYER:_____OCCUPATION:_____E-MAIL_____

HOME TEL: _____PAGER/CELL:_____WORK TEL: _____FAX:_____

PREFERRED METHOD OF CONTACT: ☐HOME TEL ☐CELL TEL ☐WORK TEL ☐EMAIL

EMERGENCY CONTACT:_____ RELATIONSHIP_____ TEL:_____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐SIGNIFICANT OTHER ☐DIVORCED ☐WIDOWED # CHILDREN_____

RACE: ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐BLACK OR AFRICAN AMERICAN
☐NATIVE OR OTHER PACIFIC ISLANDER ☐WHITE ☐PATIENT DECLINED TO PROVIDE

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐PATIENT DECLINED TO PROVIDE

PRIMARY CARE PHYSICIAN:_____ PHYSICIAN PHONE: _____

REFERRED BY: DR._____ PATIENT: _____ OTHER_____

YOU ARE *CURRENTLY* EXPERIENCING: ☐BACK PAIN ☐NECK PAIN ☐HEADACHE ☐OTHER_____

DESCRIBE☐:_____

THIS HAPPENED *WHEN?* _____ *WHERE?* ☐HOME ☐WORK ☐CAR WRECK ☐OTHER_____

THIS HAPPENED *HOW?* _____

HAVE YOU HAD THIS OR SIMILAR HAPPEN BEFORE? _____

WHAT MAKES THE PROBLEM BETTER?_____

WHAT MAKE THE PROBLEM WORSE? ☐SITTING ☐STANDING ☐LYING ☐MOVEMENT ☐REST
☐USE ☐WALKING ☐RUNNING ☐WORKING ☐ACTIVITY
☐BENDING ☐LIFTING ☐TWISTING ☐OTHER_____

DESCRIBE THE PAIN OR SENSATION: ☐ACHY ☐BURNING ☐DULL ☐NUMB ☐SHARP
☐SHOOTING ☐SORE ☐STABBING ☐STIFF ☐TINGLING

DOES THE PAIN RADIATE TO ANOTHER AREA OF THE BODY? ☐NO ☐YES - *WHERE*? _____

HOW FREQUENT IS THE PROBLEM? ☐CONSTANT ☐FREQUENT ☐INTERMITTENT ☐OCCASIONAL ☐ON/OFF
☐EVENING ONLY ☐MORNING ONLY ☐WORSE IN THE: ☐AM or ☐PM

WHAT % OF THE DAY DO YOU EXPERIENCE THIS PROBLEM? ☐0-25% ☐26-50% ☐51-75% ☐76-100%

OTHER DR.S SEEN FOR THIS CONDITION: ☐ NO ☐YES:_____WHEN? _____

PAST CHIROPRACTIC CARE: ☐NO ☐YES DRS NAME: _____WHEN? _____

PATIENT SIGNATURE: _____ DATE_____
GUARDIAN SIGNATURE: _____ DATE_____

REVIEW OF SYSTEMS AND HISTORY

Check or circle the appropriate response, please leave blank if it does not apply.

Past Medical and/or Family History

P = patient M = mother,
F = father S = Sibling

□ Heart Disease	P M F S
□ Asthma	P M F S
□ Cancer	P M F S
□ Arthritis	P M F S
□ Headaches	P M F S
□ Diabetes	P M F S
□ MVP	P M F S
□ Emphysema	P M F S
□ Anemia	P M F S
□ Fibromyalgia	P M F S
□ Hernia	P M F S
□ High BP	P M F S
□ Low BP	P M F S
□ Alzheimers	P M F S
□ Alcoholism	P M F S
□ Colitis	P M F S
□ Epilepsy	P M F S
□ Goiter	P M F S
□ Gout	P M F S
□ High Cholesterol	P M F S
□ Kidney Disease	P M F S
□ Leukemia	P M F S
□ Lupus	P M F S
□ Mental Condition	P M F S
□ Obesity	P M F S
□ Rheumatoid Arth.	P M F S
□ Ulcers	P M F S
□ Injuries	P M F S
□ Trauma auto/etc.	P M F S
□ Other_____	
_____	P M F S

Surgical History

□ Appendectomy	□ Hemorrhoid
□ Gall Bladder	□ Tonsillectomy
□ Thyroidectomy	□ Kidney Stone
□ Bladder	□ Endoscopy
□ Angioplasty	□ Heart Bypass
□ Back Surgery	□Neck Surgery

□ Arthroscopic_____
□ Joint Replacement_____

□ Mastectomy	□ Breast Implants
□ Tubaligation	□ C-Section
□ Endometriosis	□ Hysterectomy

□ Other_____
□ Other_____

Social History

Caffeine: □ No □ Light □ Heavy
Tobacco: □ No □ Yes
Packs Per day_____
Alcohol: □ No □ Yes
_____per day/week

Work History

□ No work	□ Part time
□ Full Time	□ School
□ Retired	□ Disability

Exercise

□ Frequently
□ Occasionally
□ Rarely/Never

Review Of Systems

Please circle if you have had any problems in any of the following:
(P=Past, 1=Mild, 2=Moderate, 3=Severe)

General Health

P 1 2 3 Fatigue/Tiredness
P 1 2 3 Fever/Night Sweats
P 1 2 3 Trouble Sleeping
P 1 2 3 Skin Irritation/Rash
P 1 2 3 Bleeding Disorder
P 1 2 3 Depression
P 1 2 3 Anxiety/Tension/Stress

EENT

P 1 2 3 Vision/Eye
P 1 2 3 Hearing/Ear
P 1 2 3 Throat/Swallowing
P 1 2 3 Nasal/Sinus
P 1 2 3 Headaches/Face Pain

Cardiopulmonary

P 1 2 3 Breathing
P 1 2 3 Swelling/Edema
P 1 2 3 Chest Pain

GI

P 1 2 3 Stomach/Abdominal
P 1 2 3 Diarrhea/Constipation
P 1 2 3 Vomiting

GU

P 1 2 3 Urinary Frequency/Urgency
P 1 2 3 Urinary/Burning/Discoloration
P 1 2 3 Sexual/Reproductive

Skeletal

P 1 2 3 Morning Stiffness
P 1 2 3 Night Pain
P 1 2 3 Neck Pain
P 1 2 3 Back Pain
P 1 2 3 Joint Pain_____
□ Fracture_____

NeuroMuscular

P 1 2 3 Muscle Pain
P 1 2 3 Weakness
P 1 2 3 Numbness/Tingling
P 1 2 3 Tremors/Shakes
P 1 2 3 Loss of Consciousness
P 1 2 3 Passing out

Females

Pregnant: □Yes □No □I Don=t Know
□ Last Menstrual Cycle_____

Males

□ Prostate problems

Present Medication

□None □List_____
_____
_____
_____
_____

Allergies

□ Penicillin	□ Codeine
□ Aspirin	□ Sulfa

□ Other_____
□ Other_____

Patient Signature_____Date_____
Reviewer_____Date_____

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PAIN DRAWING

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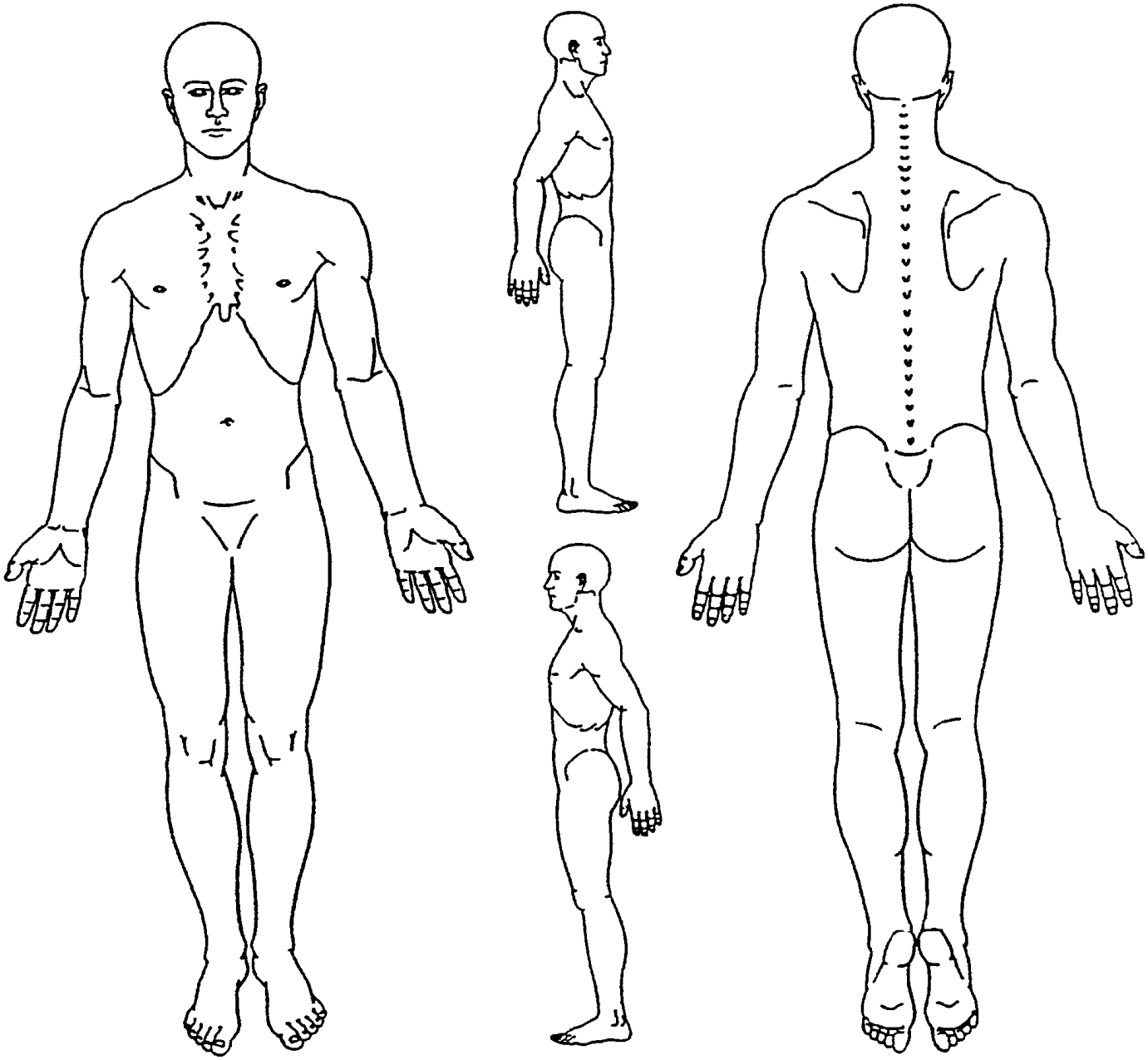
On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING



Patient Signature:_____ Date:_____

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LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Please read instructions: *This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life.* ***Please check the ONE ITEM in <u>each</u> section*** *which most closely applies.*

Section 1 - Pain intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking
- ☐ I have no pain walking.
- ☐ I have some pain walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Section 5 - Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than one hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain right away.

Section 6 - Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I have some pain when standing but it does not increase with time.
- ☐ I can't stand for longer than one hour without increasing pain.
- ☐ I can't stand for longer than 30 min. without increasing pain.
- ☐ I can't stand for longer than 10 min. without increasing pain.
- ☐ I avoid standing because it increases the pain right away.

Section 7 – Social Life
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest (dancing, etc.)
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Section 8 - Traveling
- ☐ I have no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.

Section 9 - Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed. (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed. (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed. (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed. (3-5 hours sleepless)
- ☐ My sleep is completely disturbed. (5-7 hours sleepless)

Section 10 – Changing Degree of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

PAIN SEVERITY SCALE: Rate the severity of your pain by checking **one** box on the following scale:

0	1	2	3	4	5	6	7	8	9	10

No Pain **Excruciating Pain** rev.03.27.2014

Signature:_____Date:_____

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PRIVACY NOTICE

It is the policy of HUG CHIROPRACTIC CLINIC (HCC) that all physicians and staff preserve the integrity and confidentiality of PROTECTED HEALTH INFORMATION (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice, its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients.

I, the undersigned, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. HCC has provided a copy of the PRIVACY NOTICE to me. The Privacy Notice includes a complete description of the use and/or disclosure(s) of my protected health information (PHI) necessary for HCC to provide treatment to me, and also necessary for HCC to obtain payment for that treatment and to carry out health care operations. I understand that the PRIVACY NOTICE will be available to me in the future at my request. I understand that it is my right to obtain a copy of the PRIVACY NOTICE prior to signing this Consent, and I have been encouraged to read the PRIVACY NOTICE carefully prior to my signing this CONSENT. HCC will implement reasonable measures to protect the integrity of all PHI maintained about patients.

2. HCC reserves the right to change its privacy policy that is described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by HCC:

Email, telephoning my home, cell and/or office and leaving a message on my answering machine or with the individual who answers. Birthday, thank you, and/or sentiment cards, other health-related benefits or services that may be of interest to me and patient information publications through hardcopy or electronic media

4. HCC may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for HCC to treat me and obtain payment for that treatment, and as necessary for HCC to conduct its specific health care operations.

5. I understand that I have a right to request that HCC restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, HCC is not required to agree to any restrictions that I have requested. If HCC agrees to a requested restriction, then the restriction is binding on HCC.

6. While HCC owns all medical records, the patient has a right to obtain a copy of their PHI. HCC permits patients to access their medical records when their written requests are approved by our practice. A copy of those records may be obtained within a 30 day time period.

7. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that HCC has already taken action in reliance on this consent.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Individual (Printed)	Signature of individual
_____	_____
Signature of Legal Representative	Relationship
_____	_____
Date Signed	Witness

Attorney-In-Fact, Guardian, Parent if a minor rev. 03.27.2014