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_______________ rev.03.27.2014

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_______________ rev.03.27.2014

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PAIN DRAWING

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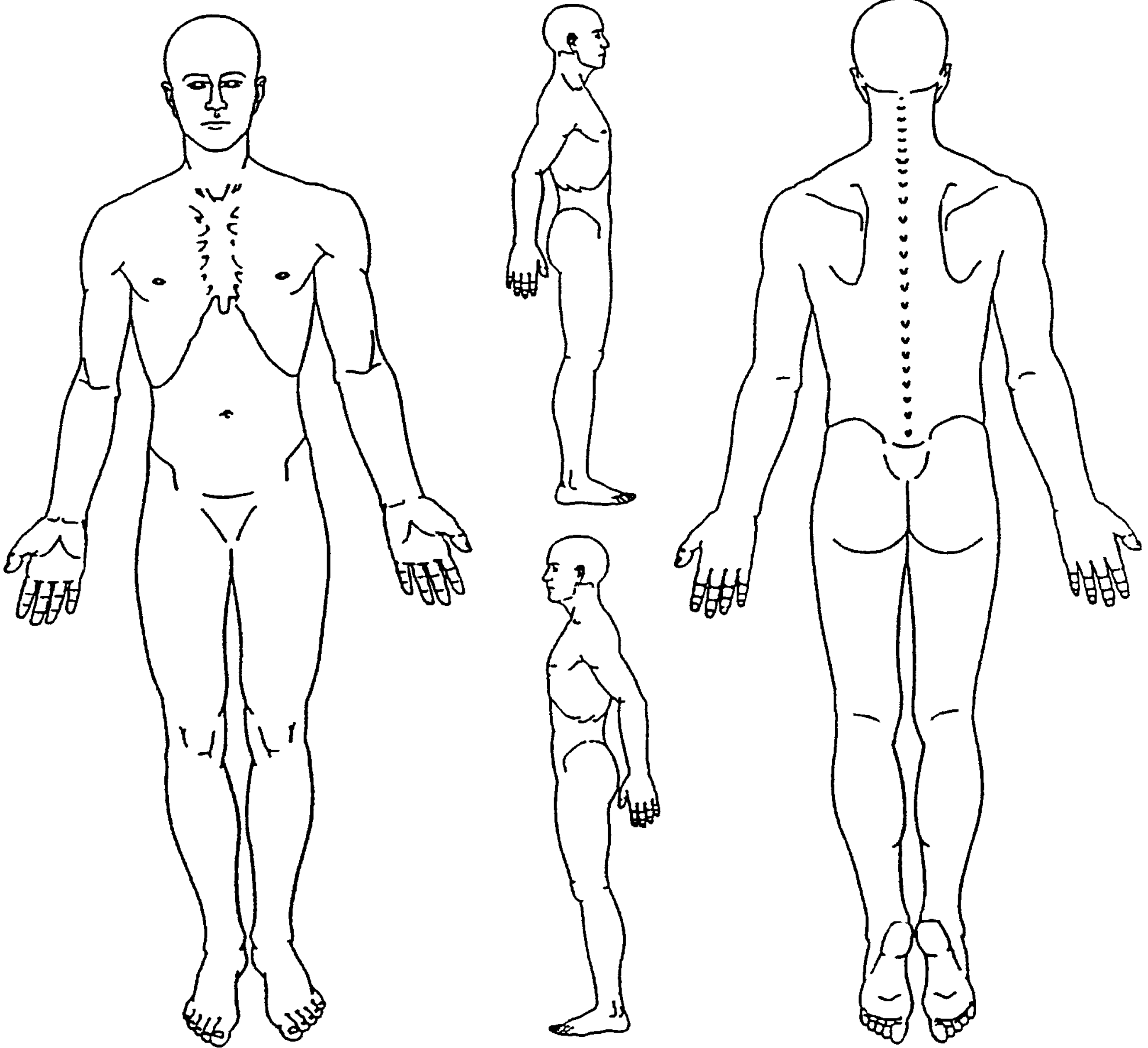
On the diagrams below please mark where you are experiencing your symptoms.

X = PAIN / DISCOMFORT
O = NUMBNESS / TINGLING



Patient Signature:____ Date:________________________

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NECK PAIN AND DISABILITY QUESTIONNAIRE (Vernon-Mior)

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 each section*** *which most closely applies to you.*

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 - Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight neck pain
- ☐ I can read as much as I want with moderate neck pain
- ☐ I can't read as much as I want because of moderate neck pain
- ☐ I can hardly read at all because of severe neck pain
- ☐ I cannot read at all

Section 5 - Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 - Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating
- ☐ I have a lot of difficulty in concentrating
- ☐ I have great difficulty in concentrating
- ☐ I cannot concentrate at all.

Section 7 - Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 - Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all

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 - Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I can't do any recreation activities at all.

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