WELCOME TO HARVEY CHIROPRACTIC

PATIENT INFORMATION

Date:_____

Name:_____

Address:_____

_____
City State Zip

Home Phone:_____

Cell Phone:_____

E-Mail:_____

Sex: M F Age:_____ Birthdate:_____

Social Security #:_____

Single Married Widowed Separated Divorced

Occupation:_____

Employer:_____

Employer Address:_____

Employer Phone:_____

Spouse's Name:_____

Birthdate:_____

Is your condition due to an accident? Yes No

Type of accident: Auto Work Home Other

Who may we thank for referring you?_____

IN CASE OF EMERGENCY, CONTACT:

Name:_____

Relationship:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

INSURANCE

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with:

_____
Primary Insurance Company

_____
Secondary/Supplemental Insurance Company

I hereby authorize and request that payment of benefits by my primary insurance company, and my secondary/supplemental insurance company (if any) be made directly to Harvey Chiropractic for services furnished to me or my dependent.

I understand that my insurance company may only cover a portion of the total bill. I further understand that I am financially responsible for all charges not covered by this assignment.

I authorize Harvey Chiropractic to release all information and/or health care records necessary to secure the payment of insurance benefits.

I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

PARENTAL CONSENT

I HEREBY AUTHORIZE Dr. David J. Harvey and whomever he may designate as his assistants to administer any necessary treatment within his scope of practice to my child:

_____
(Child's Printed Name)

Signature:_____

Printed Name:_____

Witnessed by:_____

HEALTH INFORMATION DISCLOSURE

Is there anyone beside yourself you would like us to be able to talk to regarding your health information? If so, please list them and their relationship to you below:

_____

_____

_____

_____

_____

By signing below, I attest that all above information is accurate and truthful.

X_____

PATIENT HEALTH QUESTIONNAIRE

Patient Name:_____ **Date:**_____

1. Describe your symptoms: _____

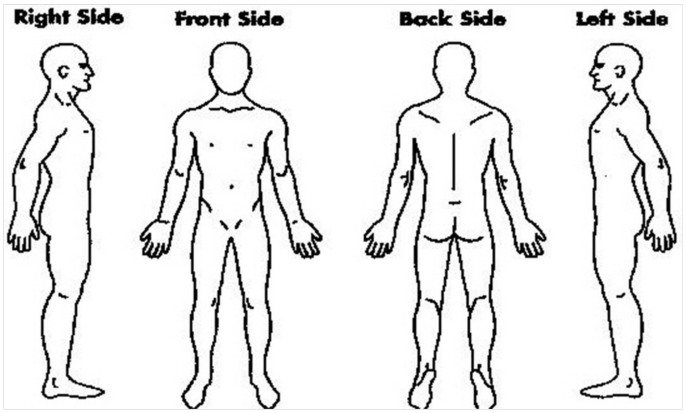
When did your symptoms start? _____

How did your symptoms begin? _____

2. How often do you experience your symptoms?

O Constantly (76-100% of the day)
O Frequently (51-75% of the day)
O Occasionally (26-50% of the day)
O Intermittently (1-25% of the day)

Please mark where you have symptoms



3. What describes the nature of your symptoms?

O Sharp O Shooting
O Dull ache O Burning
O Numb O Tingling

4. How are your symptoms changing?

O Getting better
O Not changing
O Getting worse

5. During the <u>past 4 weeks</u>:

Circle the average intensity of your symptoms: None **0 1 2 3 4 5 6 7 8 9 10** Unbearable

How much has pain interfered with your normal work (including at home and/or at work)?
O Not at all O A little bit O Moderately O Quite a bit O Extremely

6. During the <u>past 4 weeks</u> how much has your condition interfered with your social activities?
O Not at all O A little bit O Moderately O Quite a bit O Extremely

7. In general, how would your rate your overall health right now?
O Excellent O Very good O Good O Fair O Poor

8. Who have you seen for your symptoms?
O No one O Medical Doctor O Other chiropractor O Physical Therapist O Other

What treatment did you receive and when?:_____

What tests have you had for your symptoms and when were they performed:
O X-Ray date: O MRI date: O CT Scan date: O Other _____date:

9. Have you had similar symptoms in the past? O Yes O No

If you have received treatment in the past for the same or similar symptoms, who did you see?
O Medical Doctor O Other chiropractor O Physical Therapist O Other_____

10. What is/was your occupation? _____
O Full-Time O Part-Time O Self-Employed O Off Work O Unemployed O Retired

Patient Signature:_____

BACK INDEX

Patient Name:_____ **Date:**_____

This questionnaire will give your doctor information about how your symptoms affect 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 that most closely describes your situation and discuss the other with your doctor.

Pain Intensity
0 The pain is very mild and comes and goes.
1 The pain is mild and does not change.
2 The pain is moderate and comes and goes.
3 The pain is moderate and does not change.
4 The pain is very severe and comes and goes.
5 The pain is very severe and does not change.

Sleeping
0 I have no pain in bed.
1 I have pain in bed but can sleep well anyway.
2 My pain reduces my normal sleep by 25%.
3 My pain reduces my normal sleep by 50%.
4 My pain reduces my normal sleep by 75%.
5 My pain prevents me from sleeping at all.

Sitting
0 I can sit in a chair as long as I like.
1 I can only sit in my favorite chair as long as I like.
2 Increasing pain keeps me from sitting more than 1 hour.
3 Increasing pain keeps me from sitting more than 1/2 hour.
4 Increasing pain keeps me from sitting more than 10 minutes.
5 Sitting immediately increases my pain.

Standing
0 I can stand as long as I like with no pain.
1 Standing hurts a little but the pain doesn't increase.
2 I feel increasing pain if I stand for more than 1 hour.
3 I feel increasing pain if I stand for more than 1/2 hour.
4 I feel increasing pain if I stand for more than 10 minutes.
5 Standing immediately increases my pain.

Walking
0 I have no pain while walking.
1 Walking hurts a little but it doesn't increase.
2 Increasing pain keeps me from walking more than 1 mile.
3 Increasing pain keeps me from walking more than 1/2 mile.
4 Increasing pain keeps me from walking more than 1/4 mile.
5 Walking immediately increases my pain.

Personal Care
0 I can wash and dress as usual without pain.
1 I can wash and dress as usual with only mild pain.
2 I can wash and dress as usual but pain increases.
3 The pain changes the way I usually wash and dress.
4 Pain makes me need help to do some washing and dressing.
5 Pain makes me need help to do all my washing and dressing.

Lifting
0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain keeps me from lifting heavy weights off the floor.
3 Pain keeps me from lifting heavy weights off the floor but I can lift them off a table.
4 Pain keeps me from lifting heavy weights off the floor but I can lift light to medium weights off a table.
5 I can only lift very light weights.

Traveling
0 I have no pain while traveling.
1 I have some pain while traveling but my usual forms of travel don't make it worse.
2 I have extra pain while traveling but it does not cause me to seek alternate forms of travel.
3 I have extra pain while traveling and it causes me to seek alternate forms of travel.
4 Pain restricts all forms of travel unless I am able to lay down.
5 Pain restricts all forms of travel.

Social Life
0 My social life is normal and give me no extra pain.
1 My social life is normal but it increases my degree of pain.
2 Pain has no significant impact on my social life apart from limiting my more energetic interests (dancing, etc.).
3 Pain has restricted my social life and I don't go out very often.
4 Pain restricts my social life to my home. I don't go out at all.
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 staying the same (not getting better or worse).
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

DOCTOR'S USE ONLY

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

$$\left[\left(\frac{\quad}{x5}\right)\right] x100 =$$

Back Index Score: _____

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic Services None Other:_____

Name and address of other doctor(s) who have treated your condition:_____

Date of last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
MRI, CT-Scan, Bone Scan_____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:

AIDS/HIV
Alcoholism
Allergy Shots
Anemia
Anorexia
Appendicitis
Arthritis (Osteo)
Asthma
Bleeding Dis.
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Drug Addiction
Chicken Pox
Diabetes

Emphysema
Epilepsy
Fractures
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herniated Disc
Herpes
High Cholesterol
Kidney Disease
Liver Disease
Measles
Pregnancy

Miscarriage
Mononucleosis
Mult. Sclerosis
Mumps
Osteoporosis
Pacemaker
Parkinson's
Pinched Nerve
Pneumonia
Polio
Prostate Trouble
Prosthesis
Psychiatric Care
Rheumatoid Arthritis
Rheumatic Fever
Migraines
Stress

Scarlet Fever
Stroke
Thyroid Trouble
Tonsilitis
Tuberculosis
Tumors/growths
Typhoid Fever
Ulcers
Vaginal Infection
Venerial Disease
Whooping Cough
Other:_____
_____
_____
_____

EXERCISE

None
Moderate
Daily
Heavy

WORK ACTIVITY

Sitting
Standing
Light Labor
Heavy Labor

HABITS

Smoking Packs/Day_____
Alcohol Drinks/Week_____
Coffee/Caffeine Drinks Cups/Day_____
High Stress Level Reason_____

Are you pregnant? Yes No Unsure If Yes, Due Date:_____

INJURIES/SURGERIES YOU HAVE HAD **DESCRIPTION** **DATE**

Falls:_____
Broken Bones:_____
Dislocations:_____
Surgeries:_____

MEDICATIONS

_____
_____
_____
Pharmacy Name & Phone:
_____
_____

ALLERGIES

_____
_____
_____
_____
_____
_____

VITAMINS / HERBS / MINERALS

_____
_____
_____
_____
_____
_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept that patient for such care, it is essential for both parties to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will aid in preventing any confusion or disappointment.

Adjustment: An adjustment is defined as the specific and precise application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease, symptom or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of normal nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer any advice regarding treatment prescribed by other health care providers. OUR ONLY PRACTICE OBJECTIVE is to detect and eliminate vertebral subluxation and the major interference it causes to the body's innate ability to heal and be healthy. Our only method of treatment is specific adjusting by hand and/or instrument to correct vertebral subluxations.

I,_____, have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
Signature Date

PREGNANCY INFORMATION (women only)

PLEASE CHECK THE STATEMENT THAT BEST DESCRIBES YOU:

O I suspect that I may be pregnant but I am not sure. I understand that x-rays may be hazardous to an unborn child and as a precaution, they will not be used to by Dr. Harvey or his associates diagnose my condition until I am certain I am not pregnant.

O I am pregnant. My baby is due on:_____. I understand that x-rays may be hazardous to an unborn child and that they will not be used by Dr. Harvey or his associates to diagnose my condition while I am pregnant.

O I certify that to the best of my knowledge I am NOT pregnant. I give Dr. Harvey and his associates my permission to perform an x-ray evaluation. I understand that x-ray can be hazardous to an unborn child.

Date of last menstrual period:_____

_____ _____
Signature Date

INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of examinations, chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by Dr. David Harvey and/or anyone working in this office.

The nature of chiropractic treatment: The doctor will use his/her hands, or a mechanical device called an Activator to move your joints. You may hear/feel a "click" or "pop", similar to the noise that occurs when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot/cold packs and electric muscle stimulation may also be used to relax muscles or reduce pain.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications may include but are not limited to bruising, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Most commonly patients may notice stiffness or sore spots after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare" and occur about as often as complications from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

I do not expect Dr. David Harvey or his staff to be able to anticipate and explain all risks and complications. Further, I wish to rely on Dr. David Harvey to exercise judgment during the course my care and utilize procedures which he feels are in my best interests based upon the facts as they are known at that time.

Other treatment options which could be considered may include the following:

Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

Medical care, typically anti-inflammatory drugs, tranquilizers, analgesics and steroids. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization in conjunction with medical care adds cost and risk of exposure to virulent communicable disease in a significant number of cases.

Surgery in conjunction with medical care adds cost and the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows for continued or worsening symptoms, formation of adhesions, scar tissue and other permanent degenerative changes such as arthritis and degenerative disc disease. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more lengthy and difficult.

I have had the above listed unusual risks of treating my case explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent for treatment. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility. I understand that results are not guaranteed.

Printed Name	**Signature**	**Date**

WITNESS:

Printed Name	**Signature**	**Date**

NOTICE OF PRIVACY PRACTICES 1

Our Privacy Policy

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand the we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may have to disclose your health information if legally obligated/ordered to do so.
- We may need to use your health information within our practice for quality control or another operational purpose.

We have a more complete NOTICE OF PRIVACY PRACTICES that provides a detailed description of your rights, our responsibilities and how your health information may be used or disclosed. You have the right to review this notice before you sign this consent form (§164.520) or at any time. We reserve the right to change our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to ask of call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, it must be done in writing. We are not required to agree to your restrictions and if we do not, we will provide you with an explanation. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information prior to receiving your written revocation request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to access your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it's terms. I am also acknowledging that I received or may receive a copy of this notice at any time.

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES 2

Your chiropractor and members of the practice staff may need to use your name, address, phone numbers, e-mail address and clinical records to contact you with appointment reminders, questions, call-backs, information about treatment alternatives or other health-related information that may be of interest to or requested by you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form you are giving us authorization to contact you with these reminders and information and leave messages on your answering machine. Also, your health information will not be discussed with other members of your family unless authorized by you in writing. You have the right to refuse these authorizations. If you would like to do so, it must be done in writing.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization at any time; however, your revocation must be in writing, signed and delivered of mailed to Harvey Chiropractic. The practice does not have to agree to these restrictions and will not be able to honor your revocation if we have already released your health information prior to receiving your written request. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to access your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (§164.524).

This notice is effective as of the date printed below. This authorization will expire seven years after the date on which you last received service from Harvey Chiropractic.

I authorize the doctor and staff of Harvey Chiropractic to use or disclose my health information in the manner described above. I am also acknowledging that I may have a copy of this authorization at any time I desire.

Patient Printed Name	**Date**
Patient Signature	Authorized Provider Representative
Patient Representative Printed Name	Patient Representative Signature

Description of patient representative's authority to act for the patient