DUDLEY CHIROPRACTIC

Welcome to Our Office!

(Please Print) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Prof. ☐ Rev Date: _____

Last Name: _____ First: _____ Middle Initial: ____ Preferred Name:_____

Date of Birth _____ Age _____ ☐ Male ☐ Female **Marital Status** (Check one) ☐ Single ☐ Married

SSN _____ Email Address: _____

Address_____ City_____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Work Phone_____

Contact Method of Choice: ☐ Cell Phone ☐ Work Phone ☐ Home Phone ☐ E-Mail ☐ Text ☐ Other:

☐ Employed ☐ Full Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed

Occupation/Employer_____ Job Description_____

Employment Address _____ (Work Schedule) _____

Race / Ethnicity:

Multi-Racial (check one) ☐ Yes ☐ No ☐ Unknown

Race (Check one)

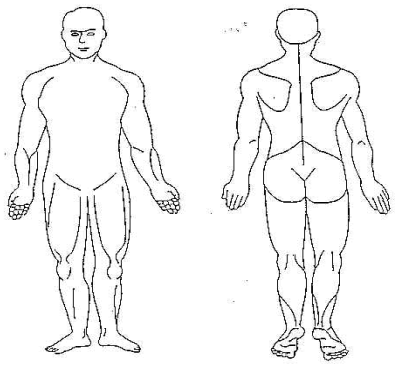
☐ White	☐ Black/African American	☐ Hispanic	☐ American Indian/Alaskan Nat.
☐ Asian	☐ Asian Indian	☐ Chinese	☐ Filipino
☐ Japanese	☐ Korean	☐ Vietnames	☐ Native Hawaiian/Pacific Island
☐ Samoan	☐ Guamanian or Chamorro	☐ Other	☐ I choose not to specify

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not specify

Preferred Language (check one)

☐ English	☐ Spanish	☐ American Sign Language	☐ Chinese
☐ French	☐ German	☐ Tagalog	☐ Vietnamese
☐ Italian	☐ Korean	☐ Russian	☐ Polish
☐ Arabic	☐ Portuguese	☐ Japanese	☐ French Creole
☐ Greek	☐ Hindi	☐ Persian	☐ Urdu
☐ Gujarati	☐ Armenian	☐ I choose not to specify	

XXXX Pain **////// Numbness**



What is the major problem you are seeking care for? (ie. Neck Pain.)

_____

_____

Additional Problems: _____

_____

Is this ☐ Work-Related ☐ Auto-Accident ☐ Slip/Fall ☐ None

(If Yes – Please fill out the Accident Injury Report)

Previous interventions, treatments for this problem: _____

_____

_____

Signature _____ ***Date*** _____

DUDLEY CHIROPRACTIC

Have you previously received Chiropractic Care? ☐ Yes ☐ No

Who? _____ When _____ Condition _____

Primary Care Physician: _____

Other Drs/Treatment Seen for this condition: _____

Previous Injury or Trauma: (Broken bones, Surgeries, etc.)_____

_____

_____

Social and Occupational History:

Recreational activities: _____

Lifestyle (hobbies, level of exercise) _____

Females/ Pregnancies and outcomes: _____

Tobacco Use: ☐ Yes ☐ Former Smoker ☐ Never been a smoker

If yes, how often do you smoke: ☐ Current every day smoker ☐ Current sometime smoker

Interest in Stopping: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No interest — Very Interested

Past Health History: (Please indicate if you have a history of the following)

☐ Major depression	☐ Bleeding issues	☐ **Cancer** _____
☐ Bipolar disorder	☐ Diabetes	☐ Lung problems/Asthma
☐ Psychiatric disorders	☐ Anticoagulant use	☐ Heart problems/high blood pressure/chest pain
☐ Schizophrenia	☐ Stroke/TIA's	☐ Other _____ ☐ None of the above

Family Health History: Do you have a **family history** of? (Please indicate all and who was affected)

☐ None of the above	
☐ Headaches _____	☐ Cardiac disease _____
☐ Neurological disease _____	☐ Adopted/Unknown _____
☐ Psychiatric disease _____	☐ Cardiac disease below 40 _____
☐ Diabetes _____	☐ Strokes/TIA's _____
☐ Cancer _____	☐ Other _____

☐ Cause and Age of Parents or Siblings Death: _____

Current Medications, including frequency and dosage, if there are no current medications, Check Here ☐

1) _____Start Date _____
2) _____Start Date _____
3) _____Start Date _____
4) _____Start Date _____
5) _____Start Date _____
6) _____Start Date _____

List any known Allergies: If no allergies are known - Check Here ☐

1) _____
2) _____
3) _____

Signature _____ ***Date*** _____

DUDLEY CHIROPRACTIC

Pediatric Only: Vaccinations: _____

Childbirth: ☐ Natural ☐ C-Section ☐ Other: _____

X-Rays Confirmation (Female): This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to X-rays or MRIs if needed. Signature _____ Date _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Security Question: Favorite Pet Security Answer: _____

Who referred you to our office so we may thank them? _____

Anything else you would like to relate?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature _____ ***Date*** _____

Name: **Date:**

EXAM HISTORY

Symptom _____ **What Happened?** _____

On a scale from 0-10, with 10 being the worst, circle the number that best describes the symptom:

Now 0 1 2 3 4 5 6 7 8 9 10 **At its Best** 0 1 2 3 4 5 6 7 8 9 10

Typically 0 1 2 3 4 5 6 7 8 9 10 **At its Worst** 0 1 2 3 4 5 6 7 8 9 10

What <u>percentage of your awake time</u> do you experience the above symptom at the above intensity?

10 20 30 40 50 60 70 80 90 100 less than 26% 26-50 51-75 76-100

When is the Worse? ☐ Morning ☐ Midday ☐ End of the Day ☐ Night ☐ Through Day ☐ Throughout Night

Does this symptom *<u>radiate</u>*? ☐ Yes ☐ No If yes, where? _____

How would you describe this symptom?

☐ Dull ☐ Sharp ☐ Throbbing ☐ Burning ☐ Deep ☐ Aching
☐ Tingling ☐ Stabbing ☐ Cramping ☐ Numbness ☐ Radiating ☐ Stiff

What activities are limited by this symptom?

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Stooping ☐ Lifting

☐ Sleeping ☐ Sneezing ☐ Coughing ☐ Straining ☐ Reaching ☐ Twist
☐ Looking ⬆ ☐ Looking ⬇ ☐ Movement ☐ Rest ☐ Lying Supine Driving
☐ Typing ☐ Scooping ☐ House Chores ☐ Exercise ☐ Lying Prone ☐ Stairs

What relieves this symptom?

☐ Sitting ☐ Standing ☐ Lying ☐ Knees Bent Up ☐ Support
☐ Adjustment ☐ No Movement ☐ Movement ☐ Heat ☐ Rest ☐ Ice
☐ Analgesic Topical ☐ Ibuprofen ☐ Medication ☐ Stretching/Exercise

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Please rate the following activities based on how they affect your daily living:

None – No Effect. **Mild** – Able to do with little pain. **Mod** – Very limited due to pain. **Severe** – Can't do

Activities	Rate the effect on activities	Activites	Rate the effect on activities
IE. Sitting *(Low Back)*	*___None ___Mild _X_Mod ___ Severe*	**Climbing Stairs**	___None ___Mild ___Mod ___ Severe
Twisting	___None ___Mild ___Mod ___ Severe	**Looking Up**	___None ___Mild ___Mod ___ Severe
Sitting	___None ___Mild ___Mod ___ Severe	**Looking Down**	___None ___Mild ___Mod ___ Severe
Standing	___None ___Mild ___Mod ___ Severe	**Movement**	___None ___Mild ___Mod ___ Severe
Walking	___None ___Mild ___Mod ___ Severe	**Rest**	___None ___Mild ___Mod ___ Severe
Bending	___None ___Mild ___Mod ___ Severe	**Lying Supine**	___None ___Mild ___Mod ___ Severe
Stooping	___None ___Mild ___Mod ___ Severe	**Driving**	___None ___Mild ___Mod ___ Severe
Lifting	___None ___Mild ___Mod ___ Severe	**Typing**	___None ___Mild ___Mod ___ Severe
Sleeping	___None ___Mild ___Mod ___ Severe	**Scooping**	___None ___Mild ___Mod ___ Severe
Sneezing	___None ___Mild ___Mod ___ Severe	**House Chores**	___None ___Mild ___Mod ___ Severe
Coughing	___None ___Mild ___Mod ___ Severe	**Exercise**	___None ___Mild ___Mod ___ Severe
Straining	___None ___Mild ___Mod ___ Severe	**Lying Prone**	___None ___Mild ___Mod ___ Severe
Reaching	___None ___Mild ___Mod ___ Severe	**Other:**	___None ___Mild ___Mod ___ Severe
Bending Neck Bwd.	___None ___Mild ___Mod ___ Severe	**Bend Fwd. at Waist**	___None ___Mild ___Mod ___ Severe
Bending Neck Fwd.	___None ___Mild ___Mod ___ Severe	**Bend Bwd. at Waist**	___None ___Mild ___Mod ___ Severe
Tilting Head Rt.	___None ___Mild ___Mod ___ Severe	**Tilting Rt. at Waist**	___None ___Mild ___Mod ___ Severe
Tilting Head Lt.	___None ___Mild ___Mod ___ Severe	**Tilting Lt. at Waist**	___None ___Mild ___Mod ___ Severe
Turning Head Rt.	___None ___Mild ___Mod ___ Severe	**Twisting Rt. at Waist**	___None ___Mild ___Mod ___ Severe
Turning Head Lt.	___None ___Mild ___Mod ___ Severe	**Twisting Lt. at Waist**	___None ___Mild ___Mod ___ Severe
Lift Right Arm above Shoulder	___None ___Mild ___Mod ___ Severe	**Lift Right Arm above Head**	___None ___Mild ___Mod ___ Severe
Lift Left Arm above Shldr	___None ___Mild ___Mod ___ Severe	**Lift Left Arm above Head**	___None ___Mild ___Mod ___ Severe
Office Use Only: Recommendations: @_____x_____for_____			

Outcome Measures Used: ☐ **QVAS** _____ ☐ **Roland Morris** ☐ **Neck Pain Disability** ☐ **Oswestry** ☐ **Bournemouth** ☐ **Other:**

		Post Rib Cage	☐☐	Rounded Shoulder	☐☐☐	Cervical Lordosis	☐☐☐
High Shoulder	☐☐	Head Tilt	☐☐	Antalgic Lean	☐☐☐	Mid-Thoracic Kyphosis	☐☐☐
Head Rotation	☐☐	Head Trans	☐☐	Minors Sign	☐☐	Lower-Thor Kyphosis	☐☐☐
Ant. Shoulder	☐☐	High Ilium	☐☐	Scoliosis ☐	Ant. Head ☐	Lumbar Lordosis	☐☐☐

NOTES:

Financial/Insurance Policy:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dudley Chiropractic will process any necessary reports and forms to assist me in making collection form the insurance company and that any amount authorized to be paid directly to Dudley Chiropractic, P.A. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Any insurance payments made to me or my Attorney will be brought into Dudley Chiropractic to be used against any balance I have. I further agree that I agree to pay all collection and attorney fees if collection or legal means are needed to settle my account.

Signature _____Date _____

Consent to treat a minor child:

I hereby authorize this office to administer chiropractic is deemed necessary for my child.

Signature _____(Parent/Legal Guardian) Date _____

Authorization to Release Information

To: James A. Dudley D.C. and/or Dudley Chiropractic, P.A.

I understand that:

* I can revoke all or part of this authorization at any time by notifying Dudley Chiropractic in writing, subject to all rights of anyone who received or disclosed information prior to receiving my revocation
* I can refuse to disclose all or some of the information in my treatment records
* A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences
* I can have a copy of this form upon request
* I can cross out any provision on this form with which I disagree

I _____ authorize Dudley Chiropractic to *EXCHANGE* any information they deem appropriate concerning my physical condition to any insurance company, attorney, adjuster, or other doctors, or Hospital or Diagnostic center in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered to you, and I hereby release you of any consequence thereof. I also give my authorization to release, use or disclose my protected health information to my PCP, Hospitals or other specialist I consult or treat with. I also authorize any x-rays, MRI's, blood work, or other diagnostic tests ordered by Dudley Chiropractic, P.A. to be released to Dudley chiropractic. My consent to release my protected health information is effective 6 months from this date.

Patient Signature _____Date _____

Witness Signature _____Date ____?_____

Consent to Treatment

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I understand that with chiropractic care there are inherent risks that I am willing to undertake. If my insurance will be billed, I authorize payment of medical benefits to James A Dudley, D.C., Dudley Chiropractic, P.A. for services performed.

Patient or Guardian Signature

_____Date_____

HIPAA Notice of Privacy Practices

I state that I have read and understand the Notice of Privacy Practices and a copy will be provided me if I ask.

_____ _____

Signature of Patient of Representative Date

_____

Printed Name