Patient Information

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Last Name ______________________________ **First Name** __________________________________ **Middle Initial** ___________

Name you prefer to go by: ____________________________ **Date of Birth** __________ / __________ / __________

SS# ______________________________________

Gender: ❐ M ❐ F **Marital Status:** ❐ Married ❐ Single ❐ Divorced ❐ Widowed ❐ Partnered

Address ____ **Apt #** ______________

City ____ **State** _____________________ **Zip** ________________________

Home Phone # _________________________ **Cell Phone #** _________________________ **Work Phone #** _________________________

Primary Number: ❐ Home ❐ Work ❐ Cell **Secondary Number:** ❐ Home ❐ Work ❐ Cell

Please note: text and email reminders are sent with minimal personal information. These messages are sent securely with our software, but once it reaches your phone/computer it is only as safe as you and your phone/email company's security.

☐ **text appointment reminders**

☐ **email appointment reminders** **email address:** ____

Your Employer ____ **Occupation** ____

Emergency Contact ____________________________________ **Phone Number** _______________________ **Relation** __________________

Whom may we thank for your referral? ____

CONDITION **Workers Compensation Related?** ❐ Yes ❐ No **Auto Accident Related?** ❐ Yes ❐ No

Informed Consent

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury.

The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Fort Wayne Chiropractic I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon request.

***Signature** ____ **Date** ________________________

My Privacy

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Fort Wayne Chiropractic to ensure the privacy of my personal health information.

***Signature** ____ **Date** ________________________

Financial Policy

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Self-Pay Patients: Our office offers a 50% time-of-service discount if services are paid for on the date of service or within 3 days of the date of service for patients with no insurance or limited coverage insurance. Should you choose to submit an insurance claim for these services on your own, our office will not appeal any claims that are denied. Should the patient or the patient's insurance company request copies of treatment notes, the patient will be required to pay for these copies.

Returned Check: In addition to the face value of the check, you will be billed a return check fee of $25.00.

Billing: By being seen at Fort Wayne Chiropractic you accept responsibility for payment of all charges incurred, which may include a 20% interest fee after 5 months of a delinquent account, as well as all collection agency costs and/or attorney fees should such actions become necessary.

All patients: by signing below you agree to everything in the above financial policy.

***Patient Name (print)** ____________________________________

***Patient Signature** ____ **Date** _______________

Failed Appointment Policy

We require that you call at least 24 hours in advance to cancel your scheduled appointment. A cancellation that is not made 24 hours in advance is considered a failed appointment. To cancel your appointment, please call Fort Wayne Chiropractic at (260) 492-8300. Do not cancel your appointment by replying to the text message or email reminders.

Appointments are scheduled every 15 minutes. If you are 15+ minutes late arriving to your scheduled appointment, this is also considered a failed appointment.

If you have <u>3 failed appointments</u> during the calendar year you will incur a $25 charge. You are responsible for any failed appointment charges that you may incur. Your insurance company does not allow this charge; therefore we will not bill your insurance.

By signing below, you understand and agree to adhere to the Fort Wayne Chiropractic Failed Appointment Policy.

***Signature** ____ **Date** _______________

We encourage you to take a detailed Office Information and Policies Pamphlet that is available to at the check-in counter. This pamphlet should answer any questions you have about Fort Wayne Chiropractic and our policies.

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Name ________________________________ **Date Of Birth** ________________

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friends in order to assist with my continuing care. This permission will be considered ongoing until I state in writing otherwise.

ALL COLUMNS MUST BE FILLED OUT FOR EACH PERSON LISTED →

Name of individual (parents and spouses must be added if they are to have any access)	**Relationship with patient**	**Specify Information Allowed**
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________
		❒ Appointment information ❒ May check balances ❒ Full access ❒ Other ______________________________

Fort Wayne Chiropractic has my permission to: (Please check all that apply)

❒ Leave detailed message **at home** with my spouse

❒ Leave detailed message **at home** with**:** NAME: ________________________ Relationship:________________

❒ Leave detailed message on my **cell phone** Cell phone number: ___________________________

❒ Leave detailed message on my **home answering machine** Home phone number: _____________________

❒ Leave detailed message on my **voicemail at work** Work phone number: ___________________________

In order to obtain information by telephone, the party calling Fort Wayne Chiropractic must be able to confirm the patient's date of birth with the staff.

____ ____________________________

*Signature of patient or legal guardian Date

Pain Assessment – Initial

Patient Name ______________________________________ **Date of Birth:** _________________

DIRECTIONS: **Check what area of your body you want the doctor to work on, one body area per complaint box.**

Were you referred to us by another medical provider for your complaints? If yes, who? ____

Complaint #1 (main complaint)

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious):

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ________________________ **What makes them worse?** ________________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ________________________

What medical care have you received for this latest occurrence of symptoms? ____

Complaint #2

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip ❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious):

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ________________________ **What makes them worse?** ________________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ________________________

What medical care have you received for this latest occurrence of symptoms? ____

Patient Signature: ________________________________ **Date:** ________________

Pain Assessment – Initial (page 2)

Patient Name ____________________________________ **Date of Birth:** ________________

DIRECTIONS: **Check what area of your body you want the doctor to work on, one body area per complaint box.**
The doctor will only work on areas that you mark on this pain assessment.

Complaint #3

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip
❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious):

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ______________________ **What makes them worse?** ______________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ______________________________

What medical care have you received for this latest occurrence of symptoms? ______________________________________

Complaint #4

Body Area (ONLY CHECK ONE!): ❒ Head ❒ Jaw ❒ Neck ❒ Upper Back ❒ Mid Back ❒ Low Back ❒ Sacrum (tailbone) ❒ Hip
❒ Ribs-front ❒ Ribs-back ❒ Arm ❒ Shoulder ❒ Hand ❒ Wrist ❒ Leg ❒ Knee ❒ Ankle ❒ Foot

What side: ❒ Right ❒ Left ❒ Both ❒ Middle **Front or back:** ❒ Front of body ❒ Back of body

Symptom Frequency: ❒ Rarely (0-25% of the day) ❒ Occasional (26-50% of the day) ❒ Frequent (51-75% of the day) ❒ Constant (76-100% of the day)

Symptoms: ❒Ache ❒Burning ❒Dull ❒Headache ❒Numbness ❒Pain ❒Sharp ❒Shooting ❒Spasms ❒Stiff ❒Tender ❒Throbbing ❒Tingling

When did this latest occurrence of symptoms begin? ______________________________ **Have you had this issue in the past?** ❒ Yes ❒ No

How have your symptoms changed since they began? ❒ Mildly improved ❒ Improved ❒ Mildly gotten worse ❒ Gotten worse ❒ Stayed the same

Current symptom severity (0= none; 3= tolerable, 5= very distressing; 8= horrible, 10= unconscious):

When do your symptoms occur? ❒Morning ❒Afternoon ❒Evening ❒During the night ❒After work ❒Other ________________________

What caused your symptoms? (ex: fell down, lifted a heavy chair) ____

What decreases your symptoms? (ex: lying down) ______________________ **What makes them worse?** ______________________

Do your symptoms radiate? (Ex: numbness in hands, pain shooting down leg) ❒ Yes ❒ No **If yes, to where** ______________________________

What medical care have you received for this latest occurrence of symptoms? ______________________________________

Patient Signature: ____________________________________ **Date:** ________________

Activities of Daily Living

Fort Wayne Chiropractic | Gregory J. Hough, D.C.

Patient Name: ________________________________ **Date:** ______________

Directions:

Please answer the following questions as they affect your lifestyle. If the activity is not affected in any way by your symptoms leave that row blank. Every body area you need the doctor to work on must be on this form.

0 = none, 1 = very mild, 2 = discomfort, 3 = tolerable, 4 = distressing, 5 = very distressing,
6 = intense, 7 = very intense, 8 = horrible, 9 = unbearable and 10 = worst pain you can imagine

Example is in blue in the first row

Fill in the column that best describes your situation

Activity	Body Area	Length of time before symptoms begin while doing activity	Symptom severity on a scale of 0/10 while doing activity
Walking	Lower back	15 Minutes / Hour(s)	5
Bending		Minutes / Hour(s)	
Employment duties		Minutes / Hour(s)	
Exercise/ Working out		Minutes / Hour(s)	
Household work		Minutes / Hour(s)	
Lifting		Minutes / Hour(s)	
Lying down		Minutes / Hour(s)	
Sitting		Minutes / Hour(s)	
Standing		Minutes / Hour(s)	
Walking		Minutes / Hour(s)	
Range of motion		Minutes / Hour(s)	
(other)		Minutes / Hour(s)	
(other)		Minutes / Hour(s)	

❒ No activity is affected in any way by my symptoms.

Patient Health History

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Patient Name: ____________________________________

If the question does not apply to you, check the "None" box. Please answer every question.

Health History/Review of Systems:

Musculoskeletal	Neurological	Head/ENT	Endocrine
❒ NONE	❒ NONE	❒ NONE	❒ NONE
❒ Muscle pain/soreness	❒ Seizures	❒ Allergies	❒ Diabetes Type 1
❒ Muscle weakness	❒ Vertigo	❒ Hearing Defect/Loss	❒ Diabetes Type 2
❒ Muscle cramps	❒ Dizziness	❒ Headaches or migraines	❒ Fatigue
❒ Muscle spasms	❒ Incoordination	❒ Ringing in ear(s	❒ Chills
❒ Joint stiffness	❒ Weak grip	❒ TMJ problems	
❒ Joint pain	❒ Paralysis	❒ Head Injury	
❒ Swollen joints	❒ Difficult speech		
❒ Low back pain	❒ Tingling	**Cardiovascular**	
❒ Mid back pain	❒ Loss of memory	❒ NONE	
❒ Upper back pain	❒ Numbness	❒ Blood Clots	
❒ Neck pain	❒ Tremors	❒ Chest pain/discomfort	
❒ Arm/Leg pain	❒ Fainting	❒ Shortness of breath	
❒ Broken bones ______________	❒ Parkinsons	❒ Heart Disease	
❒ Fractured bones ____________	❒ Concussion	❒ High Blood Pressure	
❒ Osteoporosis	❒ Alzheimers	❒ Low Blood Pressure	
❒ Arthritis	❒ Multiple sclerosis		
❒ Scoliosis	❒ Stroke		
❒ Fibromyalgia			
❒ Pins/screws ________________			

Medication allergies: ❒**NONE** ❒**Penicillin** ❒**Codeine** ❒**Sulfa drugs** ❒**Morphine** ❒ **Others** ______________________________

Current Medications (include dosage and frequency): ❒ **NONE**

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Past Imaging History (last 5 years) ❒ **NONE**

Date ____________ Type/Area __________________________ Results ________________________ ☐X-ray ☐MRI ☐CT

Date ____________ Type/Area __________________________ Results ________________________ ☐X-ray ☐MRI ☐CT

Past Hospitalization/Surgical History (last 5 years) ❒ **NONE**

Date ___________ Reason/Type of surgery _________________________ Hospital _____________ ☐ Surgery ☐ Hospitalization

Date ___________ Reason/Type of surgery _________________________ Hospital _____________ ☐ Surgery ☐ Hospitalization

Date ___________ Reason/Type of surgery _________________________ Hospital _____________ ☐ Surgery ☐ Hospitalization

Biological Family History (ex: father-diabetes): ❒ **NONE** ____

Work Habits: _____ Hours per week ☐retired ☐homemaker ☐student ☐unemployed ☐disabled ☐ light labor ☐ moderate labor ☐ heavy labor ☐ repetitive ☐ computer ☐mostly sitting ☐mostly standing ☐mostly walking ☐difficult ☐stressful

Social habits: ☐ Every day smoker ☐ Some day smoker ☐ Heavy tobacco use ☐ Light tobacco use ☐ Former Smoker ☐ Never smoked

☐ More than 6 caffeine drinks a day ☐ 3-6 caffeine drinks a day ☐ Less than 3 caffeine drinks a day ☐ No caffeine drinks a day

Exercise: ☐ Weekly ☐ Daily ☐ None

Patient Signature: ____ **Date**: ______________