

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

Home 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 3 failed appointments 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

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

Patient Name (print) _____

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
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____
		<input type="checkbox"/> Appointment information <input type="checkbox"/> May check balances <input type="checkbox"/> Full access <input type="checkbox"/> Other _____

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

- 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

Patient Name _____

Date of Birth _____

**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.**

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

Complaint #1 (main complaint)

Body Area: Head Jaw Neck Upper Back Mid Back Low Back Buttocks Hip Ribs
 Shoulder Upper arm Elbow Forearm Hand Wrist Thigh Knee Calf Ankle Foot

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

Symptom Frequency: Rare (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 occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

Have you had this issue in the past? Yes No

Since your symptoms began, have they... Mildly improved Improved Mildly worsened Worsened Stayed the same

Current symptom severity 0 (none) 1 (very mild) 2 (discomfort) 3 (tolerable) 4 (distressing) 5 (very distressing)
 6 (intense) 7 (very intense) 8 (horrible) 9 (unbearable) 10 (near unconsciousness)

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

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves 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: Head Jaw Neck Upper Back Mid Back Low Back Buttocks Hip Ribs
 Shoulder Upper arm Elbow Forearm Hand Wrist Thigh Knee Calf Ankle Foot

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

Symptom Frequency: Rare (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 occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

Have you had this issue in the past? Yes No

Since your symptoms began, have they... Mildly improved Improved Mildly worsened Worsened Stayed the same

Current symptom severity 0 (none) 1 (very mild) 2 (discomfort) 3 (tolerable) 4 (distressing) 5 (very distressing)
 6 (intense) 7 (very intense) 8 (horrible) 9 (unbearable) 10 (near unconsciousness)

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

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves 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? _____

Pain Assessment (page 2)

Patient Name _____

Date of Birth _____

**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: Head Jaw Neck Upper Back Mid Back Low Back Buttocks Hip Ribs
 Shoulder Upper arm Elbow Forearm Hand Wrist Thigh Knee Calf Ankle Foot

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

Symptom Frequency: Rare (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 occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

Have you had this issue in the past? Yes No

Since your symptoms began, have they... Mildly improved Improved Mildly worsened Worsened Stayed the same

Current symptom severity 0 (none) 1 (very mild) 2 (discomfort) 3 (tolerable) 4 (distressing) 5 (very distressing)
 6 (intense) 7 (very intense) 8 (horrible) 9 (unbearable) 10 (near unconsciousness)

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

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves 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: Head Jaw Neck Upper Back Mid Back Low Back Buttocks Hip Ribs
 Shoulder Upper arm Elbow Forearm Hand Wrist Thigh Knee Calf Ankle Foot

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

Symptom Frequency: Rare (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 occurrence of symptoms begin? If chronic, when did your symptoms get bad enough you decided to seek treatment?

Have you had this issue in the past? Yes No

Since your symptoms began, have they... Mildly improved Improved Mildly worsened Worsened Stayed the same

Current symptom severity 0 (none) 1 (very mild) 2 (discomfort) 3 (tolerable) 4 (distressing) 5 (very distressing)
 6 (intense) 7 (very intense) 8 (horrible) 9 (unbearable) 10 (near unconsciousness)

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

What caused your symptoms? (ex: fell down, lifted heavy box) _____

What improves 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? _____

Activities of Daily Living

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

Patient Name _____

Date _____

Directions: For each body area you need the doctor to treat, please choose one activity that is the most affected by your symptoms. Example is in blue in the first row

0 = none 1 = very mild 2 = discomfort 3 = tolerable 4 = distressing 5 = very distressing
 6 = intense 7 = very intense 8 = horrible 9 = unbearable 10 = worst pain imaginable

Fill in the ONE column that best describes your situation



Activity	Body Area Affected	Length of time before symptoms begin while doing activity	Symptom severity on a scale of 0-10 while doing activity
Walking	Lower back	10 <input checked="" type="checkbox"/> Minutes <input type="checkbox"/> Hours	5
Bending	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Employment duties	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Exercise/ Working out	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Household work	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Lifting	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Lying down	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Sitting	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Standing	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Walking	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Range of motion	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
(other) _____	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
(other) _____	_____	_____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____

No activity is affected in any way by my symptoms. My goal for treatment today is: _____

Patient Health History

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

Patient Name _____

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

Musculoskeletal <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint pain <input type="checkbox"/> Swollen joints <input type="checkbox"/> Low back pain <input type="checkbox"/> Mid back pain <input type="checkbox"/> Upper back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Arm/Leg pain <input type="checkbox"/> Broken bones <input type="checkbox"/> Fractured bones <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Implants/plates <input type="checkbox"/> None	Neurological <input type="checkbox"/> Seizures <input type="checkbox"/> Vertigo <input type="checkbox"/> Dizziness <input type="checkbox"/> Incoordination <input type="checkbox"/> Weak grip <input type="checkbox"/> Paralysis <input type="checkbox"/> Difficult speech <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of memory <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Fainting <input type="checkbox"/> Parkinsons <input type="checkbox"/> Concussion <input type="checkbox"/> Alzheimers <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Stroke <input type="checkbox"/> None	Head/ENT <input type="checkbox"/> Hearing Defect/Loss <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Ringing in ear(s) <input type="checkbox"/> TMJ problems <input type="checkbox"/> None Cardiovascular <input type="checkbox"/> Chest pain/discomfort <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> None
--	--	---

Have you had any imaging scans in the past that are relevant to today's treatment?

None

Date _____ Body area _____ Results _____ X-ray MRI CT
Date _____ Body area _____ Results _____ X-ray MRI CT
Date _____ Body area _____ Results _____ X-ray MRI CT

Have you had any hospitalizations or surgeries in the past that are relevant to today's treatment?

None

Date _____ Reason/Type of surgery _____ Surgery Hospitalization
Date _____ Reason/Type of surgery _____ Surgery Hospitalization
Date _____ Reason/Type of surgery _____ Surgery Hospitalization

Have you had any injuries in the past, other than those listed above, that are relevant to today's

treatment? None _____

Relevant Family History (ex: father-arthritis): None _____

Lifestyle Habits: work _____ hours/week -- light labor moderate labor heavy labor repetitive
 computer mostly sitting mostly standing mostly walking difficult stressful

Exercise Habits: Weekly Daily None

Patient Signature _____

Date _____