Hometown Chiropractic **Dr. Ryan Walton**

Patient Name: _____ Date: _____

PATIENT PERSONAL / CONFIDENTAL DATA

Address:_____City:_____ State: _____ Zip Code :_____

H. Phone: _____W. Phone:_____ Cell Phone: _____

Date of Birth:_____ Age:_____ Sex: M F Marital Status: M S D W

Email Address: _____ Social Security #_____

Name of Spouse: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Place of Employment: _____

How did you hear about our clinic? _____

Have you ever received Chiropractic Care? Yes / No If yes, when and name of Dr:_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

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. If my insurance will be billed, I authorize payment of medical benefits to **[Ryan Walton/ Hometown Chiropractic]** for services performed.

Patient or Guardian Signature _____ Date_____

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt of the Notice of Privacy Practices of Hometown Chiropractic Herein after referred to as *the Clinic*.

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 *the Clinic* to ensure the privacy of my personal health information. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name Date

_____

Signature of Patient, Parent, Legal Guardian or Patient's Legal Representative

Please list below the names and your relationship of people to whom you authorize *the Clinic* to release your private health information:

Print Name Relationship

_____

_____

_____

_____

Hometown Chiropractic **Dr. Ryan Walton**

Patient Name: _____ Date: _____

1. **Reasons for seeking chiropractic care:**
   Primary reason: _____
   Secondary reason: _____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:**
   _____
   _____

3. **Past Health History:**
   A. **Medical Conditions You Suffer From:** _____
   B. **Previous Major Injury or Trauma:** _____
   C. **Surgeries:**
   Date Type of Surgery
   _____
   _____

   D. **Allergies:**
   _____

4. **Social History:**
   A. **Caffeine Use (circle one):** Occasional, Often, Never
   Chew Tobacco (circle one): Occasional, Often, Never
   Drink Alcohol (circle one): Occasional, Often, Never

   Exercise (circle one): Occasional, Often, Never
   Smoke (circle one): Occasional, Often, Never
   Experience Stress (circle one): Occasional, Often, Never

   B. **Occupation**
   _____
   C. **Recreational activities you enjoy most**
   _____
   D. **Recreational activities most affected by your condition:**
   _____

5. **Family Health History:**

Health problems of relatives:
Parents: _____
Grandparents: _____
Siblings: _____

6. **Medications:**
   Medication Reason for taking
   _____
   _____
   _____

7. **Are you interested in (check the box)?**
   - ☐ **Pain Relief**
   - ☐ **Nutrition and Diet Information**
   - ☐ **Supplement information and comparison**
   - ☐ **Exercise information**
   - ☐ **Stress Relief**
   - ☐ **Wellness and Overall Health Improvement**
   - ☐ **Receiving bimonthly newsletters via email**

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Patient Name: _____ Date: _____

Symptom (describe symptom & location)

_____

- On a scale from 0-10, with **10 being the worst**, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- HOW did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - WHEN did the symptom begin? _____
- What **percentage of the time you are awake** do you experience the above symptom at the above intensity: 10 20 30 40 50 60 70 80 90 100
- How long does each episode last? _____
- Is the symptom worse at **certain times** of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Describe the **quality** of the symptom (circle all that apply):
  - Dull, Sharp, Sharp w/ movement, Throbbing, Burning, Deep, Aching Tingling, Stabbing, Cramping, Pinprick, Numbness, Radiating, Other (please describe): _____
- How are your symptoms **changing**? (circle one)
  - Getting better, same, getting worse
- Does the symptom **radiate** to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- What makes the symptom **worse**? (circle all that apply):
  - Sitting, Standing, Walking, Bending, Stooping, Lifting Sleeping, Sneezing, Coughing, Straining, Reaching, Twisting Looking up, Looking Down, Movement, Rest, Lying Supine, Driving, Typing, Scooping, Household Chores, Exercise, Stair Stepping, Other (please describe):_____
- What makes the symptom **better**? (circle all that apply):
  - Sitting, Standing, Lying Down, Knees bent up, Leaning against support, No movement occurs, Movement occurs, Heat is applied, Ice is applied Analgesic topical pain relief gel is applied, Ibuprofen is taken, Medication, Rest occurs, Stretching/Exercise is used, Adjustments are provided, Nothing relieves, other (please describe): _____
- Since the symptom started, how much has the pain **interfered with work**? (circle):
  - Not at all, a little bit, moderately, quite a bit, extremely, can't work
- Since the symptom started, how much has the pain interfered with your **social activities**? (circle)
  - None of the time, a little of the time, some of the time, most of the time, always
  - What social activities are **most affected** by your symptom? _____

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HEALTH QUESTIONNAIRE

PLEASE CHECK EACH OF THE CONDTINALD BELOW THAT YOU ARE CURRENTLY OR HAVE EXPERIENCED

ENTER **N** for now or **P** for past

CARDIOVASCULAR
- □ Poor Circulation
- □ High Blood Pressure
- □ Aortic Aneurism
- □ Heart Disease
- □ Vascular Disease
- □ Heart Attack
- □ Chest Pain
- □ High Cholesterol
- □ Pace Maker
- □ Jaw Pain
- □ Irregular Heartbeat
- □ Swelling of Legs

GENITO-URINARY
- □ Kidney Disease
- □ Lower Side Pain
- □ Burning Urination
- □ Frequent Urinating
- □ Blood in Urine
- □ Kidney Stone
- □ Bladder Trouble

BLOOD / LYMPH
- □ Hepatitis
- □ Blood Clots
- □ Cancer
- □ Easy Bruising
- □ Easy Bleeding
- □ Fevers/Chills/Sweats

RESPIRATORY
- □ Asthma
- □ Tuberculosis
- □ Shortness of Breath
- □ Emphysema
- □ Cold / Flu
- □ Cough/ Wheezing

CONSTITUTIONAL
- □ Weight Loss/ Gain
- □ Energy Level Problems
- □ Difficulty Sleeping

EYES, EARS, NOSE, THROAT
- □ Dizziness
- □ Hearing Loss
- □ Sinus Infection
- □ Nosebleed
- □ Sore Throat
- □ Difficulty Swallowing
- □ Bleeding Gums
- □ Glaucoma
- □ Double Vision
- □ Blurred Vision

SKIN
- □ Skin Ulcers
- □ Skin Disease
- □ Eczema
- □ Psoriasis
- □ Rashes

ALLERGIC/IMMUNE
- □ Hives
- □ Immune Disorder
- □ HIV / AIDS
- □ Allergy Shots
- □ Cortisone Use

GASTRO-INTESTINAL
- □ Gallbladder Problems
- □ Bowel Problems
- □ Constipation
- □ Liver Problems
- □ Ulcers
- □ Diarrhea
- □ Nausea/Vomiting
- □ Bloody Stools
- □ Poor Appetite

MUSCULOSKELETAL
- □ Gout
- □ Arthritis
- □ Joint Stiffness
- □ Muscle Weakness
- □ Osteoporosis
- □ Broken Bones
- □ Joints Replaced

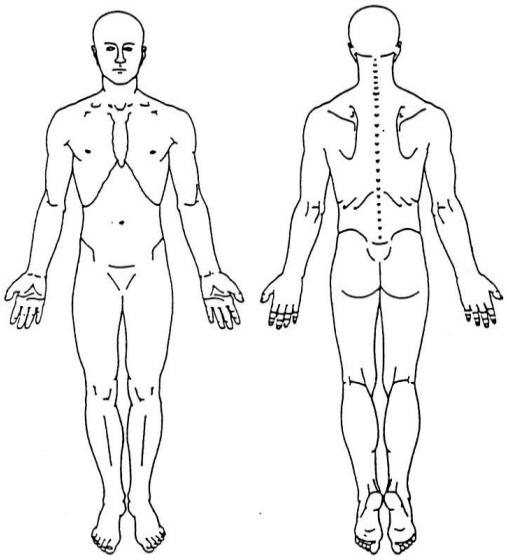
ENDOCRINE
- □ Thyroid Disease
- □ Diabetes
- □ Hair Loss
- □ Menopausal
- □ Menstrual Problems

CHILDREN
- □ C-section Birth
- □ Forceps/Vacuum Delivery
- □ Frequent Sickness
- □ Chronic Ear Infections
- □ ADD/ADHD
- □ Colic
- □ Autism

NEUROLOGICAL
- □ Stroke
- □ Seizures
- □ Head Injury
- □ Brain Aneurysm
- □ Numbness
- □ Severe Headaches
- □ Pinched Nerves
- □ Parkinson's
- □ Carpal Tunnel
- □ Spinning/Balance

PSYCHIATRIC
- □ Depression
- □ Anxiety Disorder
- □ Unusual Stress

ARE YOU PREGNANT
- □ Yes
- □ No
- □ Don't Know



Please label the location & type of pain

Numbness (N) Pins & Needles (L)
Burning (B) Dull Ache (D)
Stabbing (S) Pain (P)