AUTO COLLISION / WORK INJURY QUESTIONNAIRE

CLEAR FORM

HARRIS CHIROPRACTIC

Confidential Patient Information

Patient Legal Name:_____Preferred Name:_____

Chief Complaint: _____

Are your present symptoms or condition related to or the result of an auto collision, work- related Injury or other personal injury? (Someone else might be responsible for your payment?) ___Yes___No

Ins. Company:_____ Ins. Phone #:_____
Claim ID #:_____ Med Pay Limit:_____
Adjuster Name / Phone #:_____
Name of Policy Holder:_____ Policy Holder DOB:_____
Name of Employer (for work Injury):_____ Date of Accident:_____

WELCOME

The staff of Harris Chiropractic welcome you and want to provide the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but refer you to another healthcare provider, if appropriate.

INSURANCE

This office will do the utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

ACCEPTANCE AS A PATIENT

I understand and agree that Harris Chiropractic has the right of refusal to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the information gathering process.

CANCELLATION / RESCHEDULE / NO-SHOW POLICY

Failure to show up for your appointment OR give 24-hr notice for a cancellation/reschedule/no-show will result in a **$35 fee.** This amount will be due prior to any future appointment. If you have a credit on your account, the $35 fee will be deducted from your credit.

_____ _____

Patient Signature (or Legal Guardian) Date

last edit: 6/2/21

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CONSENT TO TREATMENT

Healthcare providers are required to advise patients of the nature of treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

* Osseous and soft tissue manipulation have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatments for spinal conditions including general pain, loss of mobility, headaches and other related symptoms.
Musculoskeletal care contributes to your overall well-being. The risk of injury or complication from treatment is substantially lower than that with many medical treatments, medications, and procedures provided for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

1. The condition that the treatment is to address
2. The nature of the treatment
3. The risks and benefits of the treatment
4. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Jeffrey Harris DC, CCSP.

_____	_____	_____
Patient Signature (or Legal Guardian)	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date

last edit: 6/2/21

Patient Name: _____ Date: _____

Address_____ City_____ State _____ Zip _____

H. Phone _____ W. Phone_____ Cell Phone _____

Email Address: _____

Sex ☐ M ☐ F Marital Status ○ M ○ S ○ D ○ W Date of Birth_____ Age _____

Occupation _____

Employer _____

Emergency Contact / Phone Number: _____

Height _____ Weight _____ B/P (if known) _____ HR_____ O2_____

Have you ever received Chiropractic Care? ◯ Yes / No ◯ If yes, when? _____

Name of most recent Chiropractor: _____

1 | **SINCE THE MOTOR VEHICLE COLLISION, HAVE YOU EXPERIENCED AND OF THE FOLLOWING:**

A. Loss of Range of Motion. ◯ Yes / No ◯
   a. What body parts: _____

B. Visual Disturbance: ○ Yes / No ○
   ☐ Blurring ○ L / R ○ ☐ Floaters ○ L / R ○ ☐ Vision Loss ○ L / R ○ ☐ Hypersensitivity ○ L / R ○
   % of time: _____ % of time: _____ % of time: _____ % of time: _____

C. Dizziness: ☐ Yes / No ☐ % of time: _____

D. Anxiety/Depression: ☐ Yes / No ☐ % of time: _____

E. Difficulty Sleeping: ☐ Yes / No ☐

2 | **PAST HEALTH HISTORY**

A. SURGICAL HISTORY

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

B. PREVIOUS INJURY OR TRAUMA? _____

Have you ever broken any bones? Which? _____

C. ALLERGIES: _____

PREGNANCY (past or current)? _____

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3 | FAMILY HEALTH HISTORY

Do you have a family history of? (Please indicate all that apply)

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

A. DEATHS IN IMMEDIATE FAMILY:

Cause of parents' or siblings' death	Age at death
_____	_____
_____	_____
_____	_____
_____	_____

4 | SOCIAL & OCCUPATIONAL HISTORY

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

5 | MEDICATIONS

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Dr. Jeff Harris DC, CCSP - 314 W Main St MIddleton, ID 83644 | Tel: 208.424.5100 Fax: 208.424.3225 Harris-Clinic.com

HARRIS CHIROPRACTIC

Patient Name: _____ Date: _____

REVIEW OF SYMPTOMS

Have you had any of the following **pulmonary (lung-related)** issues?
☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other _____ ☐ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease ☐ Heart attacks/MIs
☐ Heart disease/problems ☐ Hypertension ☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat
☐ Other _____ ☐ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
☐ Visual changes/loss of vision ☐ One-sided weakness of face or body ☐ History of seizures ☐ One-sided decreased feeling in the face or body ☐ Headaches ☐ Memory loss ☐ Tremors ☐ Vertigo ☐ Loss of smell ☐ Strokes/TIAs
☐ Other _____ ☐ None of the above

Have you had the following **endocrine (glandular/hormonal)** related issues or procedures?
☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements ☐ Diabetes
☐ Other _____ ☐ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
☐ Renal calculi/stones ☐ Hematuria (blood in the urine) ☐ Incontinence (can't control) ☐ Bladder Infections
☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other _____ ☐ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
☐ Nausea ☐ Difficulty swallowing ☐ Ulcerative disease ☐ Frequent abdominal pain ☐ Hiatal hernia
☐ Pancreatic disease ☐ Irritable bowel/colitis ☐ Hepatitis or liver disease ☐ Bloody or black tarry stools
☐ Vomiting blood ☐ Bowel incontinence ☐ Constipation ☐ Gastroesophageal reflux/heartburn
☐ Other _____ ☐ None of the above

Have you had any of the following **hematological (blood-related)** issues?
☐ Anemia ☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Alieve) ☐ HIV positive
☐ Abnormal bleeding/bruising ☐ Sickle-cell anemia ☐ Enlarged lymph nodes ☐ Hemophilia
☐ Hypercoagulation or deep venous thrombosis/history of blood clots ☐ Anticoagulant therapy ☐ Regular aspirin use
☐ Other _____ ☐ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
☐ Significant burns ☐ Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other _____ ☐ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
☐ Rheumatoid arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones ☐ Spinal fracture ☐ Spinal surgery
☐ Joint surgery ☐ Arthritis (unknown type) ☐ Scoliosis ☐ Metal implants ☐ Other _____ ☐ None of the above

Have you had any of the following **psychological** issues?
☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations ☐ Bipolar disorder ☐ Homicidal ideations ☐ Schizophrenia
☐ Psychiatric hospitalizations ☐ Other _____ ☐ None of the above

Any past medical history that you feel is important to your care here? _____

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 Harris Chiropractic for services performed.

Patient or Guardian Signature _____ Date_____

last edit: 6/2/21

HARRIS CHIROPRACTIC

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient of Representative Date

_____

Printed Name

last edit: 6/2/21

HARRIS CHIROPRACTIC

Patient Name: _____ Date: _____

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Symptom # _____ Please describe: _____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time (circle one): 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Did the symptom begin (circle one) Suddenly or Gradually

When did the symptom begin? _____

How did the symptom begin? _____

What makes the symptom worse? (circle all or state all that apply):

nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed,
other (please describe): _____

What makes the symptom better? (circle or state all that apply):

nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

Describe the quality of the symptom (circle or state all that apply):

Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
Other (please describe): _____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate? _____

Is the symptom worse at certain times of the day or night? (please circle)

No difference Morning Afternoon Evening Night Other _____

Have you received treatment for this condition and episode prior to today's visit?

☐ No ☐ Anti-inflammatory meds ☐ Pain meds ☐ Muscle relaxers ☐ Cortisone injections
☐ Trigger point injections ☐ Surgery ☐ Massage ☐ Physical Therapy ☐ Chiropractic
☐ Other _____

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