SWEARY CHIROPRACTIC

Name: _____ **DOB**: _____

Nickname: _____ **SSN**: _____

Address: _____ **Phone**: _____

_____ **Alt. phone**: _____

Would you like to receive electronic communication from our clinic? **Email**: _____

Primary Care Physician: _____

Emergency Contact: _____ **Phone**: _____

Referred by: _____ ☐ Internet ☐ Yellow Pages ☐ Insurance

Occupation: _____

DEMOGRAPHICS

Preferred language: ☐ English ☐ Spanish ☐ Other:_____

Hand dominance: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Smoking status: ☐ Everyday smoker ☐ Occasional smoker ☐ Former smoker ☐ Never smoked

If smoker, when did you start or quit smoking? _____ to _____

Race:

- ☐ I do not wish to provide this information
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other:_____

Ethnicity:

- ☐ I do not wish to provide this information
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other:_____

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have children? ☐ Yes ☐ No If yes, how many? _____

Do you use: ☐ Coffee ☐ Tobacco ☐ Alcohol

WEARY CHIROPRACTIC

INITIAL EVALUATION – Non-Accident Related

Name: _____ Date: _____

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No ☐ Retired

Can you tolerate your job activities? ☐ Yes ☐ No

If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Please select any of the activities below that you are currently experiencing problems with:

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating
☐ Hearing	☐ Bathing	☐ Grooming	☐ Dressing
☐ Reading	☐ Typing	☐ Writing	☐ Grasping
☐ Holding	☐ Pinching	☐ Standing	☐ Leaning
☐ Walking	☐ Stooping	☐ Squatting	☐ Climbing
☐ Kneeling	☐ Bending	☐ Twisting	☐ Carrying
☐ Lifting	☐ Pushing	☐ Pulling	☐ Reaching
☐ Sitting	☐ Driving	☐ Riding in a car	☐ Air travel
☐ Sports	☐ Exercising	☐ Sex drive	☐ Reclining
☐ Restful sleeping	☐ Insomnia	☐ Using the toilet	☐ Concentration
☐ Nervous	☐ Irritable	☐ Personality change	☐ _____

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Medical History

☐ Not currently prescribed any medications

☐ No known medication allergies

Prescription medication you are currently taking:

_____

_____

_____

Any known allergies:

_____

_____

_____

Please select all conditions that you currently have or had in the past:

☐ NONE
☐ Abdominal pain
☐ Abnormal weight gain/loss
☐ Angina
☐ Anorexia
☐ Anxiety
☐ Aortic aneurysm
☐ Arthritis
☐ Asthma
☐ Bladder infection
☐ Blood disorder
☐ Breast lumps
☐ Breast soreness
☐ Bronchitis
☐ Cancer
☐ Cardiovascular disease/heart attack
☐ Chest pain
☐ Chronic cough
☐ Chronic sinusitis
☐ Colitis
☐ Constipation
☐ Convulsions
☐ COPD
☐ Depression
☐ Dermatitis/Eczema
☐ Diabetes
☐ Difficulty swallowing
☐ Dizziness
☐ Emphysema
☐ Endometriosis
☐ Epilepsy
☐ Excessive thirst
☐ Fainting
☐ Frequent urination
☐ General fatigue
☐ Gout
☐ Headache
☐ Heartburn/Indigestion
☐ Hepatitis
☐ High blood pressure
☐ High cholesterol
☐ High PSA
☐ High triglycerides
☐ Hypertension
☐ Jaw pain
☐ Kidney disorders/stones
☐ Liver/Gallbladder problems
☐ Loss of bladder control
☐ Lung disease
☐ Mental disease
☐ Muscular imbalance
☐ Osteoarthritis
☐ Painful urination
☐ PMS
☐ Pneumonia
☐ Prostate problems
☐ Rapid heart beat
☐ Renal disease
☐ Rheumatoid arthritis
☐ Scoliosis
☐ Stroke
☐ Swelling/Stiffness of joints
☐ Thyroid disease
☐ Tinnitus (ear noises)
☐ Tuberculosis
☐ Tumor
☐ Ulcer
☐ Visual disturbances

Surgical History

☐ NONE
☐ Abortion
☐ Abdominal exploration
☐ Abdominoplasty
☐ ACL reconstruction:
Date: _____
Location: _____
☐ Adenoid removal
☐ Angioplasty
☐ Appendectomy
☐ Bone fracture repair:
Date: _____

Location: _____

- ☐ Carotid artery surgery
- ☐ Cataract surgery
- ☐ Cervical spine surgery:

Date: _____

Location: _____

- ☐ Cosmetic breast surgery
- ☐ C-Section
- ☐ Gallbladder removal
- ☐ Gastric bypass surgery
- ☐ Heart surgery
- ☐ Hemorrhoid surgery
- ☐ Hernia repair
- ☐ Hip joint replacement

Date: _____

Location: _____

- ☐ Hysterectomy
- ☐ Kidney transplant
- ☐ Knee arthroscopy:

Date: _____

Location: _____

- ☐ Knee joint replacement:

Date: _____

Location: _____

- ☐ Knee surgery:

Date: _____

Location: _____

- ☐ LASIK eye surgery
- ☐ Liposuction
- ☐ Lumbar spine surgery:

Date:_____

- ☐ Mastectomy
- ☐ Prostate removal
- ☐ Rotator cuff surgery
- ☐ TMJ surgery
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Other:_____

_____

_____

_____

_____

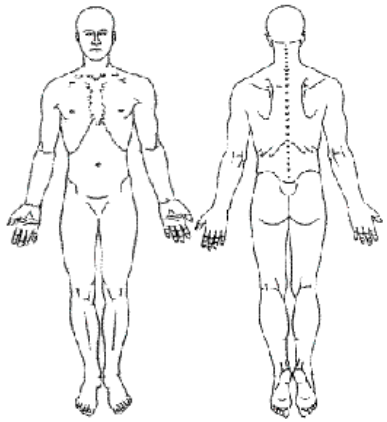
_____

_____

Family Medical History

- ☐ NONE
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Depression
- ☐ Dermatitis/Eczema
- ☐ Diabetes
- ☐ Headache
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disorders/stones
- ☐ Mental disease
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Stroke

Complaint #1 **Please mark on the picture where your symptoms are occurring and answer the questions to the right:**



This complaint came on: ☐ gradually ☐ immediately

and it is: ☐ improving ☐ staying the same ☐ getting worse

The intensity of this complaint is: ☐ minimal ☐ moderate ☐ severe

The frequency of the pain is: ☐ occasional ☐ frequent ☐ constant

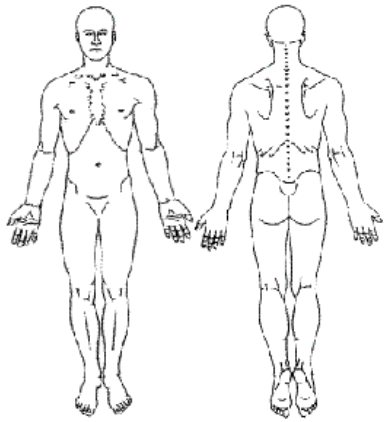
and it feels like: ☐ dull ☐ sharp ☐ aching ☐ shooting ☐ spasm ☐ throbbing ☐ burning ☐ tingling

The pain is located on: ☐ left side ☐ right side ☐ both sides

Please rate your pain for this complaint:

0-10 Numeric Pain Rating Scale

Complaint #2 **Please mark on the picture where your symptoms are occurring and answer the questions to the right:**



This complaint came on: ☐ gradually ☐ immediately

and it is: ☐ improving ☐ staying the same ☐ getting worse

The intensity of this complaint is: ☐ minimal ☐ moderate ☐ severe

The frequency of the pain is: ☐ occasional ☐ frequent ☐ constant

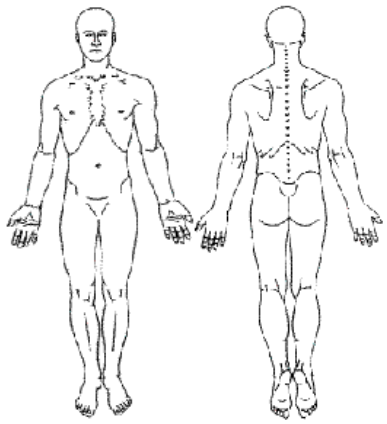
and it feels like: ☐ dull ☐ sharp ☐ aching ☐ shooting ☐ spasm ☐ throbbing ☐ burning ☐ tingling

The pain is located on: ☐ left side ☐ right side ☐ both sides

Please rate your pain for this complaint:

0-10 Numeric Pain Rating Scale

Complaint #3 **Please mark on the picture where your symptoms are occurring and answer the questions to the right:**



This complaint came on: ☐ gradually ☐ immediately

and it is: ☐ improving ☐ staying the same ☐ getting worse

The intensity of this complaint is: ☐ minimal ☐ moderate ☐ severe

The frequency of the pain is: ☐ occasional ☐ frequent ☐ constant

and it feels like: ☐ dull ☐ sharp ☐ aching ☐ shooting ☐ spasm ☐ throbbing ☐ burning ☐ tingling

The pain is located on: ☐ left side ☐ right side ☐ both sides

Please rate your pain for this complaint:

0-10 Numeric Pain Rating Scale

Patient Name_____ Date:_____

Rate each function as follows: 0 = not at all, 1-3 = slightly, 4-6 = moderately, 7-10 = severely

1. Does your pain interfere with your normal work inside and outside the home?

Work normally — Unable to work at all

0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel to see doctors

0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

No problems — Cannot sit/stand at all

0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems — Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems — Cannot walk/run at all

0 1 2 3 4 5 6 7 8 9 10

8. Has your income declined since your pain began?

No decline — Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?

No medication needed — On pain medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problem — Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference — Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help — Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension — Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems — Severe problems

0 1 2 3 4 5 6 7 8 9 10

WEARY CHIROPRACTIC

Authorizations and agreements with Bruce A. Weary DC, Ltd
dba Weary Chiropractic. Please read carefully and sign/date each section.

For _____
Printed Patient Name

Informed Consent: I request and give my consent for chiropractic manipulation and related treatment. I intend for this consent to cover all treatment now and in the future by Bruce A. Weary, DC or any other doctor he appoints to administer treatment. I will receive the **Spinal Care Treatment: The Risks and Benefits** pamphlet upon check-out and I agree to read and inform myself of the risks and benefits of chiropractic care.

_____ _____
Patient or Guardian signature Date

Medical Insurance: I authorize the medical insurance company to pay directly for chiropractic services received. I, however, understand that both I and the person who signs below are responsible for all my fees, including any fees not paid by insurance. If my insurance company has not paid the submitted charges 60 days from the date of service, it then becomes my responsibility to pay my account in full.

Weary Chiropractic Clinic will submit services rendered to your insurance company using the benefit explanation provided to our office during the verification process. However, insurance carriers often do not quote your benefits correctly and therefore, insurance verification and benefits quoted to our office are not a guarantee of payment and hence, you are responsible for payment of your account.

_____ _____
Patient or Guardian signature Date

Release of Information: I authorize Weary Chiropractic Clinic to release information about me to the medical insurance company and to the referring physician or healthcare professional participating in my health care.

_____ _____
Patient or Guardian signature Date

Financial Responsibility: I, the undersigned, understand and agree that I am responsible for (my) the patient's fees to Weary Chiropractic Clinic, including any fees not paid by the medical insurance; that if the account is not paid when due, reasonable collection and court costs will be paid by the undersigned.

_____ _____
Patient or Guardian signature Date

730 N Montezuma St Suite B Prescott, AZ 86301
Phone: 928.778.2227 • Fax: 928.771.9159

WEARY CHIROPRACTIC

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 read it carefully.

We care about your privacy and strive to protect the confidentiality of your medical information. New Federal legislation requires that we provide this official notice of our privacy practices. You have the right to the confidentiality of your medical information and we maintain that confidentiality as required by Federal Law. We will abide by the terms of this Notice and provide notice of the legal duties and practices with respect to protected health information.

Any health care professionals authorized to enter information into your medical record, all employees, staff and other personnel at this office who may have access to your information must abide by this law. This office may share medical information with others for treatments, payment purposes or health care operations described in this Notice. Only necessary information will be shared.

The following categories describe different way that we may disclose medical information without your specific consent or authorization. Not every possible use or disclosure in a category is listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. For example, in treating you for a specific condition, we may need to know if you have allergies that could influence which treatment or medications could be used.

For Payment: We may use and disclose medical information about you so that treatments and services you receive by us may be billed and payment may be collected from you, an insurance company or third party. For example, we may need to disclose your name, address, office visit date and codes identifying your diagnosis and treatment.

For Health Care operations: We may use and disclose information about health care operations to assure you receive quality care. For example, we may use information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other uses or disclosures that can be made without consent or authorization:

- To avert serious threat to public safety or health; Health oversight activities
- As required during an investigation by law enforcement agencies or in response to a legal proceeding
- To military command authorities/worker's compensation or similar programs for their medical records
- If an inmate, to the correctional institute or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Uses and disclosures required by law; other health care providers' treatment activities
- Other covered entities' and providers' payment activities and health care operations permitted under HIPPA
- Uses and disclosures in domestic violence or neglect situations; Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

_____ _____

Patient's signature Date

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Phone: 928.778.2227 • Fax: 928.771.9159