Harcourt
Chiropractic Office, LLC
*Gary E. Harcourt, DC*

Dear Patient,

Welcome to our office! Our office was established in 1952 by Dr. Robert Harcourt. He had an impressive influence on his sons. Three of them attended National College of Chiropractic. Dr. Gary Harcourt is a third generation chiropractor. His son, Adam, is a graduate from Life West Chiropractic College in San Francisco, CA which makes the Harcourt family fourth generations. Dr. Adam is practicing in Santa Barbara, CA. Dr. Gary has participated in extensive training in Chiropractic Orthopedics. He is also a certified wellness practitioner. Our office offers an array of treatment options to enhance and support your health.

Our office team will be happy to assist you in any way to ensure you have a wonderful experience with not only your chiropractic care, but with our office. We are here to provide you with the care and treatment necessary to relieve you of your symptoms and get you back to enjoying your life!

To Your Health,

The Harcourt Team ☺

*1630 W. Market Street • York, PA 17404 • 717-843-2542 • fax 717-846-4727 • www.yorkrelief.com*

# HARCOURT CHIROPRACTIC OFFICE, LLC

## INFORMATION/APPLICATION FOR CARE

Patient's name____________________ What name do you prefer to go by?__________

Home address____________________ City ______ State______ Zipcode______

Home phone (____) ______-______ **Cell phone (____) ______-______** Patient's S.S # __________

Date of birth ____/____/____ Age______ Male ☐ Female ☐ Status: S M W D

Email __________@__________ (We send our periodic health tips and special information as it becomes available through E-mail)

Maiden name__________ children ages/sex:

Is any member of your family a patient at this office? YES ☐ NO ☐ Relationship__________

How were you referred to our office? Name of the person that referred you: __________
☐ Phone book ☐ Outside lecture/Health Fair ☐ Spinal Health Care Class ☐ Another Physician ☐ Website ☐ Facebook ☐ ERN
☐ Friend ☐ Family member ☐ Chiro-Exchange/Groupon ☐ Info. In mail ☐ Newsletter ☐ Office Sign ☐ Attorney ☐ Insurance Company
☐ Internet ☐ Other __________

Your Employer ____________________ Your Postion__________

Employer's address ____________________ City ______ State______ Zip code______

Employer's Phone Number (____)______-______ Ext.______

Spouse's Name ____________________ Spouse's Employer ____________________

Spouse's Postion__________ Spouse's Employer's Number (____)______-______ Ext. ______

**Emergency Contact** __________ **Home phone (____)** ______-______ **Cell phone (____)** ______-______

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____/____/____ Date injury or illness began? Are you ☐ right or ☐ left handed?
☐ Yes ☐ No Have you ever had the same or similar symptoms? Explain __________
☐ Yes ☐ No Is this condition the result of pregnancy? **If yes, estimated due date:** ____/____/____
☐ Yes ☐ No Is your present health problem the result of a work related accident?
☐ Yes ☐ No If yes, was your employer notified?
☐ Yes ☐ No Is your present health problem the result of a motor vehicle accident?
☐ Yes ☐ No Is there an open insurance claim in process now?
☐ Yes ☐ No May we call you at work for additional information if necessary?
☐ Yes ☐ No Have you lost any time from work?
☐ Haven't returned to work at this time
☐ Returned to work on ____/____/____ Dates of disability ____/____/____ to ____/____/____

Hospital Preference ☐ York Hospital ☐ Memorial Hospital ☐ Other__________
**Name of Family Doctor**__________ Phone # (____)______-______ Date of last exam: ____/____/____

☐ Yes ☐ No Would you be interested in receiving appointment reminders via text or email?
☐ Yes ☐ No Would you like to receive one statement per family? List Family members__________
☐ Yes ☐ No Would you like to receive periodic health tips and special information by email when it becomes available?

**HIPPA-Who may we release information to regarding your care/appointments/etc?** __________

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## PAYMENT GUARANTEE / AUTHORIZATION TO RELEASE INFORMATION

In consideration of Harcourt Chiropractic Office, York, PA., rendering care and/or treatment to the patient named below, I/we the undersigned promise to pay Harcourt Chiropractic Office, in full, upon demand, all expenses and charges for such care or treatment. I/we that, if as a courtesy, Harcourt Chiropractic Office bills my/our insurance company, this is no way relieves my/our obligation.

I authorize Harcourt Chiropractic Office to release to any third party reimburser, your employer, hospital or continued care facility such information for this condition as may be necessary for the evaluation and/or payments of my medical claim or continuation of care after release. I also authorize all healthcare providers, hospitals, offices and clinics where I have been a patient to release to Harcourt Chiropractic Office all information relative to my medical history or condition.

In the event it is necessary to engage the services of a collection agency or attorney for collection of this claim, I/we agree to be responsible for reasonable fees and costs charges by said agency or attorney for collection.

I have had this form fully explained to me and I/we have read it and I/we fully understand and accept its terms and conditions. A photocopy of this agreement shall be considered as effective and valid as the original.

Signature____________________ Witness____________________ Date____/____/____
(Patient or Authorized Representative)

# Harcourt Chiropractic Office, LLC Health History Questionnaire

Name: ______________________________ (PLEASE MARK THE BOXES THAT BEST DESCRIBE YOUR CONDITION)

## HEADACHE PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Throbbing
Location = ☐ Right ☐ Left ☐ Face
☐ Forehead ☐ Back of head
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ____________________

## NECK PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Throbbing
☐ Clicking/cracking ☐ Grinding/rubbing
Location = ☐ Right ☐ Left ☐ Face
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ____________________

## MIDDLE BACK PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Throbbing
☐ Difficulty Breathing ☐ Chest Pain
Location = ☐ Right ☐ Left ☐ Central
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ____________________

## LOWER BACK PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Burning
☐ Numbing ☐ Radiating into leg(s)
Location = ☐ Right ☐ Left ☐ Central
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ____________________

## SHOULDER/ARM/HAND PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Burning
☐ Numbness ☐ Coldness ☐ Weakness
Location = ☐ Right ☐ Left ☐ Both
☐ Shoulder ☐ Arm ☐ Hand
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ____________________

## HIP/LEG/FOOT PAIN

Intensity = ☐ Severe ☐ Moderate ☐ Annoying
Frequency = ☐ Daily ☐ Weekly ☐ Monthly
Character = ☐ Dull ☐ Sharp ☐ Burning
☐ Numbness ☐ Coldness ☐ Weakness
Location = ☐ Right ☐ Left ☐ Both
☐ Hip ☐ Leg ☐ Foot
Location is ☐ Always the same ☐ can vary

How long have you had these symptoms? ____________________

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Include all affected areas.
Just to complete the picture, please draw in your face.

Numbness = = = = = = = = = Burning xxxxxxxxxxxx

Pins and needles oooooooooo Stabbing Pain / / / / / / /

Nagging/dull pain: : : : : : : Shooting pain ########

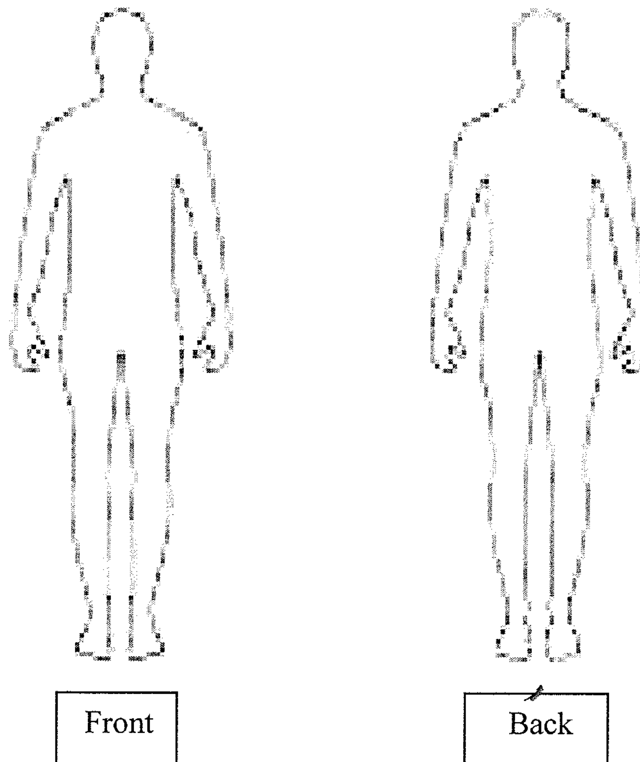
Radiation of Pain = ☐ Yes ☐ No
Aggravating Factors ☐ Sitting ☐ Standing
☐ Bending ☐ Reaching ☐ Other ____________
Alleviating Factors: ☐ Sitting ☐ Standing
☐ Laying ☐ Ice ☐ Heat
☐ Support ☐ Medication ☐ Other ____________

Associated Complaints: ______________________________

______________________________________________

Comments: ______________________________________

______________________________________________



☐ Yes ☐ No Have you had previous chiropractic care? Dr. ______________________
If yes, how long has it been since you've been treated: ____________?
☐ Yes ☐ No Were you hospitalized? Date admitted __/__/__ Date Discharged __/__/__
☐ Yes ☐ No Were you treated in another facility for this condition? Where ______________________
☐ Yes ☐ No Have x-rays been taken or was lab worked proposed and/or completed? When? ______________
☐ Yes ☐ No Have you had any operations? Explain ______________________
List any drugs you are taking: ______________________
☐ Yes ☐ No Do you have morning stiffness which lasts more than 30 minutes?
☐ Yes ☐ No Are you interested in improving your general well being as well as dispensing with the symptoms that brought you to our office?

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Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, take time to answer these questions carefully as these problems can affect your overall diagnosis, treatment plan, and whether or not you are accepted for care.

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☐ Yes ☐ No Have you ever had cancer?
☐ Yes ☐ No Are you losing weight without trying?
☐ Yes ☐ No Does your pain wake you up at night?
☐ Yes ☐ No Have you had a change in bladder or bowel habits?
☐ Yes ☐ No Have you had a sore that doesn't heal?
☐ Yes ☐ No Have you recently had any unusual bleeding or discharge?
☐ Yes ☐ No Do you have a thickening/ lump in breast anywhere?
☐ Yes ☐ No Are you having indigestion or difficulty swallowing?
☐ Yes ☐ No Do you have a nagging cough or hoarseness?
☐ Yes ☐ No Have you had an obvious change in a wart or mole?

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Circle any of the following conditions you currently have or that tend to be recurrent problems. Check (√) those you have had in the past but are no longer a problem.

| GENERAL | EENT | GASTRO-INTESTINAL | FEMALE | NERVOUS SYSTEM |
|---|---|---|---|---|
| Headaches | Eye problems | Poor appetite | Menstrual pain | Numbness |
| Allergies | Ear problems | Excessive Hunger | Menstrual irregularity | Paralysis |
| Hay fever | Nasal/sinus problems | Difficult swallowing | Vaginal pain | Dizziness |
| Hives | Throat trouble | Difficult chewing | Vaginal infection | Fainting |
| Fatigue | Loss of taste | Excessive thirst | Vaginal discharge | Confusion |
| Weight Loss | Loss of smell | Frequent nausea | Vaginal bleeding | Forgetfulness |
| | | Vomiting | Breast pain/lumps | Depression |
| CARDIOVASCULAR/RESPIRATORY | GENITO-URINARY | Abdominal pain | Hot flashes | Convulsions |
| Chest pain | Pain/burning on urination | Diarrhea | Are you pregnant? | Muscle jerks |
| Difficult breathing | Difficulty starting to urinate | Constipation | ☐ Yes ☐ No | Nervousness |
| Persistent cough | Inability to control urine | Black/bloody stool | Date of last period? | Neuralgia |
| Blood pressure problems | Frequent urination | Hemorrhoids | __/__/__ | Insomnia |
| Asthma or bronchitis | Discolored urine | Indigestion | | |
| Rapid or irreg. heartbeat | Bladder trouble | Gas of bloating | | |
| Swollen ankles | Kidney infection or stones | Liver trouble | | |
| Varicose veins | Sexual dysfunction | Gall bladder problems | | |
| Hardening of arteries | Prostate troubles (male) | Colon trouble | | |
| Legs hurt after walking | | | | |

**IMPORTANT: DO YOU HAVE A PACEMAKER?** ☐ **YES** ☐ **NO**

Circle any of the following diseases you have or had.

| | | | | | | |
|---|---|---|---|---|---|---|
| Appendicitis | Malaria | Chicken pox | Alcoholism | Typhoid fever | Goiter | Polio |
| Scarlet fever | Tuberculosis | Diabetes | Arthritis | Mental disorder | Lumbago | Influenza |
| Venereal disease | Cancer | Anemia | Heart disease | Rheumatic fever | Eczema | Small pox |
| Whooping cough | Epilepsy | Pneumonia | Measles | Diphtheria | Mumps | Pleurisy |
| AIDS | | | | | | |

Signature: ______________________ Date ___/___/___

Comments: ______________________

## *Social History:*

| | | | | | |
|---|---|---|---|---|---|
| Marital status | Single | Married | Divorced | Widowed | Separated |

| | | | | |
|---|---|---|---|---|
| Do you smoke? | Yes | No | Packs/day | How many years? |
| Do you drink alcohol? | Yes | No | Drinks/day | Drinks per week |
| Do you drink caffeine? (soda, tea, coffee) | Yes | No | Drinks/day | |
| What is your current exercise level? | Minimal | | Moderate | Intense |
| What is your stress level (mental/emotional)? | Low | | Moderate | High |
| Do you sleep: | Well | | Moderate | Poor |

List your favorite hobbies from most to least:

List your personal interests:

## *Occupational History:*

What is your occupation? How long?

| | | | |
|---|---|---|---|
| Lifting requirements: | Heavy (more than ½-body weight) | Medium (1/4-body weight) | Light (less than 10 lb) |

| | | | | |
|---|---|---|---|---|
| Satisfaction level of your current job: | Super | Good | Average | Poor |

| | | | | |
|---|---|---|---|---|
| Education: | Grade School | High School | College Graduate | Post Graduate |

## *These are the things I currently do to enhance and support my health:*

| | | |
|---|---|---|
| Drink plenty of water | Eat organically grown foods | Vitamins / minerals / herbs |
| Exercise regularly | Maintain the proper weight | Get plenty of rest |
| Receive regular massages | Acupuncture | Meditate / pray |
| Yoga / Pilates / aerobics | Counseling or therapy | Orthotics or heel lifts |
| Drink alcohol in moderation | Use a cervical pillow | Self help books |
| Attend religious services | Maintain a positive attitude | Colonoscopy |
| Homeopathic remedies | Annual physical examination | Laughter |

| ______________________ | ______________________ | ______________ |
|---|---|---|
| Name | Signature | Date |