

HARCOURT CHIROPRACTIC OFFICE, LLC
CONFIDENTIAL PATIENT INFORMATION

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

Home address _____ City _____ State _____ Zipcode _____

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

Best Time to Reach you? ____ am ____ pm 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 Office Sign Another Physician Spinal Health Care Class Dr. Tim Harcourt
 Friend Val-Pak Coupon Info. In mail Newsletter Newspaper Ad Dr. Gary Harcourt
 Family member Mall/Health Fair Radio Ad Insurance Company Attorney

Your Employer _____ Your Position _____

Employer's address _____ City _____ State _____ Zip code _____

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

Spouse's Name _____ Spouse's Employer _____

Spouse's Position _____ Spouse's Employer's Number (____) _____ - _____ Ext. _____

Emergency Contact _____ **Home phone** (____) _____ - _____ **Cell phone** (____) _____ - _____

____/____/____ 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: ____/____/____

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 in no way relieves my/our obligation.

I authorize Harcourt Chiropractic Office to release to any third party reimbursor, 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)

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 _____

Yes No 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?

The following questions 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.

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?

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.

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

Circle any of the following diseases you have or had.

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

Date ___/___/___

Comments: _____

Family History

(Check all that apply)

	Diabetes	Heart Disease	Heart Attack	Stroke	Cancer	Disc Disease	Chronic Pain Back/Neck	Scoliosis (Curvature of spine)	Spinal Injury	Physician/Medicine Dependence
Father										
Mother										
Brother(s)										
Sister(s)										
Grandparents										

Other Significant illnesses/accidents _____ Date ___/___/___

_____ Date ___/___/___

Social History

Circle: Single Married Divorced Seperated

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

Do you use nonprescription/illicit drugs? Yes No What kind?

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 1/2 body weight) Medium (1/4 body weight) Light (less than 10 lbs)

Satisfaction level of your current job: Super Good Average Poor

Education: Grade School High School College Graduate Post Graduate

_____ Name

_____ Signature

_____ Date