

**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  Billboard Ad  Spinal Health Care Class  Another Physician  
 Friend  Val-Pak Coupon  Info. In mail  Newsletter  Newspaper Ad  Office Sign  Dr. Tim Harcourt  
 Family member  Mall/Health Fair  Radio Ad  Insurance Company  Attorney  Dr. Gary Harcourt

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** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_ 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Best time to reach?** \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

**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 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)

**PREGNANCY RELEASE**

This is to certify that, to the best of my knowledge, I am NOT pregnant and that the HARCOURT CHIROPRACTIC OFFICE has permission to take X-rays.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Harcourt Chiropractic Office, LLC Health History Questionnaire

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

|  |  |
|--|--|
| <p style="text-align: center;"><b>HEADACHE PAIN</b></p> <p>Intensity = <input type="checkbox"/> Severe   <input type="checkbox"/> Moderate   <input type="checkbox"/> Annoying<br/>                 Frequency = <input type="checkbox"/> Daily   <input type="checkbox"/> Weekly   <input type="checkbox"/> Monthly<br/>                 Character = <input type="checkbox"/> Dull   <input type="checkbox"/> Sharp   <input type="checkbox"/> Throbbing<br/>                 Location = <input type="checkbox"/> Right   <input type="checkbox"/> Left   <input type="checkbox"/> Face<br/>                               <input type="checkbox"/> Forehead   <input type="checkbox"/> Back of head<br/>                 Location is <input type="checkbox"/> Always the same   <input type="checkbox"/> can vary</p> <p>How long have you had these symptoms?</p>  | <p style="text-align: center;"><b>NECK PAIN</b></p> <p>Intensity = <input type="checkbox"/> Severe   <input type="checkbox"/> Moderate   <input type="checkbox"/> Annoying<br/>                 Frequency = <input type="checkbox"/> Daily   <input type="checkbox"/> Weekly   <input type="checkbox"/> Monthly<br/>                 Character = <input type="checkbox"/> Dull   <input type="checkbox"/> Sharp   <input type="checkbox"/> Throbbing<br/>                               <input type="checkbox"/> Clicking/cracking   <input type="checkbox"/> Grinding/rubbing<br/>                 Location = <input type="checkbox"/> Right   <input type="checkbox"/> Left   <input type="checkbox"/> Face<br/>                 Location is <input type="checkbox"/> Always the same   <input type="checkbox"/> can vary</p> <p>How long have you had these symptoms?</p>   |
| <p style="text-align: center;"><b>MIDDLE BACK PAIN</b></p> <p>Intensity = <input type="checkbox"/> Severe   <input type="checkbox"/> Moderate   <input type="checkbox"/> Annoying<br/>                 Frequency = <input type="checkbox"/> Daily   <input type="checkbox"/> Weekly   <input type="checkbox"/> Monthly<br/>                 Character = <input type="checkbox"/> Dull   <input type="checkbox"/> Sharp   <input type="checkbox"/> Throbbing<br/>                               <input type="checkbox"/> Difficulty Breathing   <input type="checkbox"/> Chest Pain<br/>                 Location = <input type="checkbox"/> Right   <input type="checkbox"/> Left   <input type="checkbox"/> Central<br/>                 Location is <input type="checkbox"/> Always the same   <input type="checkbox"/> can vary</p> <p>How long have you had these symptoms?</p>  | <p style="text-align: center;"><b>LOWER BACK PAIN</b></p> <p>Intensity = <input type="checkbox"/> Severe   <input type="checkbox"/> Moderate   <input type="checkbox"/> Annoying<br/>                 Frequency = <input type="checkbox"/> Daily   <input type="checkbox"/> Weekly   <input type="checkbox"/> Monthly<br/>                 Character = <input type="checkbox"/> Dull   <input type="checkbox"/> Sharp   <input type="checkbox"/> Burning<br/>                               <input type="checkbox"/> Numbing   <input type="checkbox"/> Radiating into leg(s)<br/>                 Location = <input type="checkbox"/> Right   <input type="checkbox"/> Left   <input type="checkbox"/> Central<br/>                 Location is <input type="checkbox"/> Always the same   <input type="checkbox"/> can vary</p> <p>How long have you had these symptoms?</p>   |
| <p style="text-align: center;"><b>SHOULDER/ARM/HAND PAIN</b></p> <p>Intensity = <input type="checkbox"/> Severe   <input type="checkbox"/> Moderate   <input type="checkbox"/> Annoying<br/>                 Frequency = <input type="checkbox"/> Daily   <input type="checkbox"/> Weekly   <input type="checkbox"/> Monthly<br/>                 Character = <input type="checkbox"/> Dull   <input type="checkbox"/> Sharp   <input type="checkbox"/> Burning<br/>                               <input type="checkbox"/> Numbness   <input type="checkbox"/> Coldness   <input type="checkbox"/> Weakness<br/>                 Location = <input type="checkbox"/> Right   <input type="checkbox"/> Left   <input type="checkbox"/> Both<br/>                               <input type="checkbox"/> Shoulder   <input type="checkbox"/> Arm   <input type="checkbox"/> Hand<br/>                 Location is <input type="checkbox"/> Always the same   <input type="checkbox"/> can vary</p> <p>How long have you had these symptoms?</p> | <p style="text-align: center;"><b>HIP/LEG/FOOT PAIN</b></p> <p>Intensity = <input type="checkbox"/> Severe   <input type="checkbox"/> Moderate   <input type="checkbox"/> Annoying<br/>                 Frequency = <input type="checkbox"/> Daily   <input type="checkbox"/> Weekly   <input type="checkbox"/> Monthly<br/>                 Character = <input type="checkbox"/> Dull   <input type="checkbox"/> Sharp   <input type="checkbox"/> Burning<br/>                               <input type="checkbox"/> Numbness   <input type="checkbox"/> Coldness   <input type="checkbox"/> Weakness<br/>                 Location = <input type="checkbox"/> Right   <input type="checkbox"/> Left   <input type="checkbox"/> Both<br/>                               <input type="checkbox"/> Hip   <input type="checkbox"/> Leg   <input type="checkbox"/> Foot<br/>                 Location is <input type="checkbox"/> Always the same   <input type="checkbox"/> can vary</p> <p>How long have you had these symptoms?</p> |

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 #####

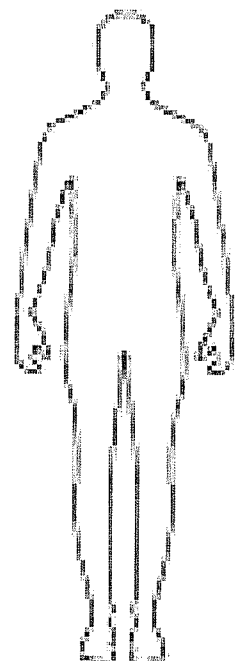
Radiation of Pain =  Yes    No  
 Aggravating Factors  Sitting    Standing  
                            Bending    Reaching    Other \_\_\_\_\_  
 Alleviating Factors:  Sitting    Standing  
                            Laying    Ice    Heat  
                            Support    Medication    Other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

Associated Complaints: \_\_\_\_\_

Comments: \_\_\_\_\_



Front



Back

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?

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.

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.

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

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

Circle any of the following diseases you have or had.

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

Signature: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Comments: \_\_\_\_\_

***Social History:***

|   |         |          |            |                 |
|---|---------|----------|------------|-----------------|
| Marital status                                | Single  | Married  | Divorced   | 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 |                 |
| 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 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