**PRESENT COMPLAINT Elizabeth Henry-Burnett, DC Referral From\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your present complaint? Where do you feel the problem? Describe your symptoms

Where & How did this start?

Have you ever had this problem in the past? \_\_\_\_\_\_\_\_\_\_ If yes, when and what kind of treatment was used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequent is your problem? (check one)

\_\_\_constant (76-100%) \_\_\_\_frequent (51-75%) \_\_\_occasional (26-50%) \_\_\_\_hardly ever (25% or less)

How bad is your pain? (circle) no pain 1 2 3 4 5 6 7 8 9 10 pain is unbearable

Is your complaint affecting your ability to work or otherwise be active?

\_\_ No effect

\_\_ Some physical restrictions (able to perform light duty work & household tasks.)

\_\_ Need limited assistance with common every day tasks.Need assistance often

\_\_ Need assistance often

\_\_ Have a significant inability to function without assistance.

\_\_ Am totally disabled (impaired). Cannot care for self.

Indicate which of the following activities make your symtom(s) better (B) or worse (W)?

\_\_\_\_\_\_Sitting \_\_\_\_\_\_Standing \_\_\_\_\_Bending down \_\_\_\_\_Bending back \_\_\_inactivity \_\_\_\_\_\_Lying down \_\_\_\_\_Movement/activity

Where is pain located? Please Mark on Chart.

Does the pain radiate into the arms or legs? Yes No

Are you taking any medications (including over-the-counter such as Tylenol)? \_\_\_\_\_\_\_If yes, please list below…..

|  |  |  |
| --- | --- | --- |
| Name of Medication | Amount you take per day | Why do you take it (condition)? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

List any surgeries or broken bones you have had, the month/year performed, and description of what surgery was for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe and tell the month/year of any previous falls, auto accidents, or serious injuries

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_ If yes, how many cigarettes do you smoke per day? \_\_\_\_\_for \_\_\_\_\_\_(#) years

How may alcoholic beverages (beer, wine, liquor) do you consume in an average week? \_\_\_\_\_\_\_

**Has your use of alcohol or other chemicals increased since your symptom(s) began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been to a chiropractor before? If yes, may I ask whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

FAMILY ~ PERSONAL ~ MEDICAL HISTORY Elizabeth Henry-Burnett, DC

|  |  |  |  |
| --- | --- | --- | --- |
| Family History* Diabetes
* Thyroid disease
* Tuberculosis
* Kidney disease
* High blood pressure
* Heart disease
* Stroke/Aneurysm
* Cancer
* Muscular disease
* Other

**Hospitaliztions & Medications*** Hospitalizations
* Current use of any prescription or recreational drugs
* Cardiac pacemaker, etc.
* Insulin pump
* Other
 | General History* Trauma/injuries
* Height change
* Weight change
* Fever/chills
* Sweats
* Allergies
* Anemia
* Bleeding/bruising
* Malaise/fatigue
* Weakness
* Cancer
* Stroke
* Seizures or Tics
* Dizziness/fainting
* Other

Reproductive System* Sexual difficulties
* Change in sex drive
* Other
 | Endocrine System* Heat/cold intolerance
* Thyroid problems
* Diabetes
* Neck surgery/irradiation
* Change in Hair/ Skin/ Texture/ Temperature
* Nervousness
* Anger
* Anxiety/Depression
* Stressed
* Visual problems
* Other eye problems
* Deafness/ Hearing Aids
* Ear pain
* Change in ability to smell
* Frequent colds
* Other
 | **Cardiovascular Sys.*** Shortness of breath

Time of day \_\_\_\_\_\_How often \_\_\_\_\_\_\_* Chest pain/tightness

Type \_\_\_\_\_\_\_\_\_\_\_How often \_\_\_\_\_\_\_* Sudden calf pain

Is it while walking?\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_* High blood pressure
* Past heart disease
* Rheumatic fever
* Swelling of ankles
* Varicose veins
* Wheezing/asthma
* Chronic Cough
* Tuberculosis/ exposure to it
* Lung infections
* Other
 |
| Musculoskeletal* Arthritis
* Joint pain/stiffness
* Fibromyalgia
* Joint swelling
* Muscle cramps/twitching
* Muscle weakness
* Change in size of muscle(s)
* Neck pain
* Mid-back pain
* Low back pain
* Tailbone pain
* Hip problem
* Arm problem
* Leg problem
* Fractures/ sprain/ strain
* Osteoporosis
* Pins & needles feeling in arms/hand
* Bad posture

 \* Date of last bone density test:\_\_\_\_\_\_\_\_\_\_\_ | * Pins & needles feeling in legs/feet
* Scoliosis
* Other

**Gastrointestinal System*** Change in appetite
* Food intolerance
* Nausea/vomiting
* Peptic ulcer
* Indigestion/ heartburn
* Abdominal pain
* Change in stool/color/etc.
* Diarrhea/ constipation
* Hernia
* Gallbladder
* Pancreatitis
* Pain upon urination
* Change in urine color/etc.
* Difficulty in starting/holding stream
 | Jaundice Frequent urinationDay\_\_\_ Night \_\_\_\_Daily fluid intake* Flank pain
* Kidney infection/disease
* Pelvic pain
* Bed wetting
* Prostate trouble
* Other

Female Patients* # pregnancies \_\_\_\_
* # children\_\_\_\_\_\_\_\_
* Difficult delivery
* Pregnant @ this time
* Excessive flow
* Menstrual cramping
* Fluid retention
* PMS
 | * Bumps/lumps/mass in breasts
* Menarche (1st period)

 Age \_\_\_\_\_Menstrual regularity:Days in cycle \_\_\_\_\_Duration \_\_\_\_\_daysFirst day of last cycle \_\_\_\_\_\_\_\_\_\_\_* Date of last PAP test

\_\_\_\_\_\_\_\_\_\_\_\_* Hysterectomy

Date:\_\_\_\_\_\_\_\_\_\_\_\_* Menopause:
* Hysterectomy

Date:\_\_\_\_\_\_\_\_\_\_\_\_* Menopause:

 Onset age \_\_\_\_\_\_\_* Post menopausal bleeding
* Hot flashes
* Other
 |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark any condition or symptoms you have had in the past or are currently experiencing.**

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS Todays Date**: \_\_\_\_/\_\_\_\_\_/20\_\_\_\_

Name of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred name to be called:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender M / F

City, State & Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #1: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OK to leave message?** Yes:\_\_\_\_\_\_\_No:\_\_\_\_\_\_

Phone #2: Cell or Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OK to leave message ?** Yes:\_\_\_\_\_\_\_No:\_\_\_\_\_\_

Employer Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □Single □Married □Other E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Address/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY INFORMATION**

Name of Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURED/FINANCIALLY RESPONSIBLE PARTY**

Guarantor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do they live with you? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_ If no, please include their address below

Address/City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this a work related or vehicle injury or litigation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

* I consent to treatment by Elizabeth Henry(-Burnett), D.C.
* I authorize the release of necessary medical information for insurance purposes.
* I authorize and request that insurance payments be made directly to Elizabeth A. Henry (-Burnett), D.C. should she elect to receive such payment.
* I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status.
* I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that this notice may be changed at any time. I may obtain a revised copy of the Notice from this office.
* I have read and fully understand the above consent for treatment, financial responsibility obligations, and insurance authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Parent or Guardian:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:

*Elizabeth Henry-Burnett, D.C. ● 22295 Hwy 6 & 19. ● Cambridge Springs, PA 16403 ● 814-398-2887 ● Fax 814-398-2903*

**INFORMED CONSENT FOR MINORS at**

**HENRY-BURNETT CHIROPRACTIC**

Elizabeth Henry-Burnett, DC

The primary treatment used by a doctor of chiropractic is the spinal adjustment or manipulation. This is the primary procedure I will use to treat you. Any joint in the body may be adjusted, including the joints in the arms, legs, hands, and feet. Other therapies may be used in your treatment and may include: hot packs, cold packs, ultrasounds, Russian stim, bi-phasic, intraferential, Alpha stim, and nutritional advice.

**● Nature of the Chiropractic Adjustment**

I will use my hands or a mechanical device to manipulate joints in areas that are not moving properly. The adjustment may cause an audible “pop” or “click”, similar to the sound heard when cracking your knuckles. You may feel or sense movement in that area. The adjustment is performed to introduce movement in areas that are not moving properly, so that your nervous system can work optimally, without interference.

**● Material Risks of the Chiropractic Adjustment**

As with any health care procedure, there are certain complications which may arise during treatment. These complications include: fractures, disc injuries, dislocations, muscle strain and bruising, joint sprains, stiffness, and soreness. Some types of manipulation have been associated with injuries to the arteries in the neck, which could contribute to serious complications including stroke.

**● Probability of Risks Occurring**

Fractures are rare occurrences and generally result from an underlying weakness of the bone. Therefore, it is imperative that you inform the doctor if you suffer from osteoporosis or other disorder that may compromise your bone density. An article by R.S. Hosek in the Journal of the American Medical Association states that the risk of stroke being caused by a *chiropractor* is one-in-a-million.

**● Other Treatment Options**

Other treatment options include: over-the-counter drugs, rest, physical therapy, surgery, hospitalization, religious counseling, and medical care with prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers.

**● Risks & Dangers to Remaining Untreated**

Remaining untreated allows the formation of adhesions and reduces mobility which sets up inflammation and a possible pain reaction further reducing mobility. Over time, this may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is high.

**I have read or have had read to me the above explanation of the chiropractic adjustment, the risks, other treatment options and the consequences of remaining untreated. The doctor has informed me of my condition and proposed treatment plan. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I consent to chiropractic treatment.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name Signature of Parent/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Witness’ Name Signature of Witness Date

**NOTICE OF PRIVACY PRACTICES**

**HENRY CHIROPRACTIC 22295 Rt 6 & 19 CAMBRIDGE SPRINGS, PA 16403**

**ELIZABETH HENRY-BURNETT, D.C.**

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

**PLEASE REVIEW CAREFULLY**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control your health information. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose you health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

* **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
* **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this is sending a bill for your visit to your insurance company for payment.
* **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to receive an accounting of disclosures of your protected health information.

The right to obtain a paper copy of this no