HEMBREE CHIROPRACTIC REGISTRATION

PATIENT INFORMATION

Date: ______________________________

Patient: ______________________________

Address: ______________________________

____
City State Zip

Home/Cell #: ______________________ Work #: ______________________

Sex: ☐ M ☐ F Age ________ Birthdate ______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#: ______________________ Occupation: ______________________

Employer: ______________________ Employer Phone: ______________________

Employer Address: ______________________________
City State Zip

Spouse's Name: ______________________________

Spouse's Birthdate: ______________________ Spouse's SS#: ______________________

Spouse's Occupation: ______________________ Spouse's Employer: ______________________

Emergency Contact (other than spouse): ______________________________

Relationship: ______________________ Cell #: ______________________

How were you referred to Hembree Chiropractic? ______________________________

If another patient referred you, please give us their name so that we may show our appreciation to them. ______________________________

PATIENT HISTORY

Date of Last Physical Exam: ______________________

Is there any possibility that you are pregnant? ☐ Yes ☐ No

Mark any conditions from which you have suffered:

- ☐ Dizziness
- ☐ Backaches
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Arthritis
- ☐ Headaches
- ☐ Asthma
- ☐ Neuritis
- ☐ Digestive Disorders
- ☐ Nervousness
- ☐ Sinus Trouble
- ☐ Neck Pain

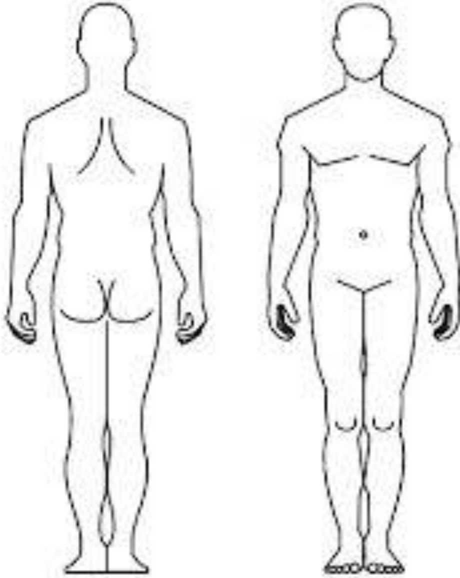
PATIENT CONDITION

Reason for Visit: ____

When did your symptoms appear? ______________________________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): ________

Type of pain: ☐ Sharp ☐ Dull
☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling
☐ Other ____________________

How often do you have this pain? _______
____

Is it constant or does it come and go? _____
____

Does it interfere with your: ☐ Work ☐ Sleep
☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ _______________

Is condition due to an accident? ☐ Yes ☐ No Date of accident: __________________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐Employer ☐ Worker's Comp. ☐ Other

Attorney Name (if applicable): ____

Have you ever had any other personal injury or accident? ☐ Yes ☐ No

If yes, please describe: ____

____

QUADRUPLE VISUAL ANALOG SCALE

Patient Name: ______________________________ Date: ______________

Please read carefully:
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each individual complaint following the code below. Please indicate your pain level right now, average pain, and pain at its best and worst.

H = Head	N = Neck	UB = Upper Back	MB = Mid Back	LB = Low Back
SH = Shoulder	E = Elbow	W = Wrist	HP = Hip	K = Knee
CH = Chest	TMJ = Jaw	O = Other (Explain: _____________________________)		

Example:

No Pain ______ H ______ N ______ LB ______ Worst Possible Pain
0 1 (2) 3 4 (5) 6 7 (8) 9 10

1 - What is your pain RIGHT NOW?

No Pain ________________________________ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2 - What is your TYPICAL or AVERAGE pain?

No Pain ________________________________ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain ________________________________ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain ________________________________ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

____

____

____
Examiner

Oswestry Disability Index

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally but it is very painful.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more then 1mile.
- ☐ Pain prevents me walking more than ¼ of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours sleep.
- ☐ Because of pain, I have less than 4 hours sleep.
- ☐ Because of pain, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 – Social Life

- ☐ My social life is normal and cause me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports.,
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys of over two hours.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ☐ No
- ☐ Yes (If yes, please state the type of treatment you have received)

Neck Disability Index

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment. (0)
- ☐ The pain is very mild at the moment. (1)
- ☐ The pain is moderate at the moment. (2)
- ☐ The pain is fairly severe at the moment. (3)
- ☐ The pain is very severe at the moment. (4)
- ☐ The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain. (0)
- ☐ I can look after myself normally but it causes extra pain. (1)
- ☐ It is painful to look after myself and I am slow and careful. (2)
- ☐ I need some help but manage most of my personal care. (3)
- ☐ I need help every day in most aspects of self care. (4)
- ☐ I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain. (0)
- ☐ I can lift heavy weights but it gives extra pain. (1)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- ☐ I can lift very light weights. (4)
- ☐ I cannot lift or carry anything at all. (5)

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck. (0)
- ☐ I can read as much as I want to with slight pain in my neck. (1)
- ☐ I can read as much as I want with moderate pain in my neck. (2)
- ☐ I cannot read as much as I want because of moderate pain in my neck. (3)
- ☐ I can hardly read at all because of severe pain in my neck. (4)
- ☐ I cannot read at all. (5)

Section 5 – Headaches

- ☐ I have no headaches at all. (0)
- ☐ I have slight headaches that come infrequently. (1)
- ☐ I have moderate headaches which come infrequently. (2)
- ☐ I have moderate headaches which come frequently. (3)
- ☐ I have severe headaches which come frequently. (4)
- ☐ I have headaches almost all the time. (5)

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty. (0)
- ☐ I can concentrate fully when I want to with slight difficulty. (1)
- ☐ I have a fair degree of difficulty in concentrating when I want to. (2)
- ☐ I have a lot of difficulty in concentrating when I want to. (3)
- ☐ I have a great deal of difficulty in concentrating when I want to. (4)
- ☐ I cannot concentrate at all. (5)

Section 7 – Work

- ☐ I can do as much work as I want to. (0)
- ☐ I can do my usual work, but no more. (1)
- ☐ I can do most of my usual work, but no more. (2)
- ☐ I cannot do my usual work. (3)
- ☐ I can hardly do any work at all. (4)
- ☐ I cannot do any work at all. (5)

Section 8 – Driving

- ☐ I can drive my car without any neck pain. (0)
- ☐ I can drive my car as long as I want with slight pain in my neck. (1)
- ☐ I can drive my car as long as I want with moderate pain in my neck. (2)
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- ☐ I can hardly drive at all because of severe pain in my neck. (4)
- ☐ I cannot drive my car at all. (5)

Section 9 – Sleeping

- ☐ I have no trouble sleeping. (0)
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- ☐ My sleep is mildly disturbed (1-2 hours sleepless). (2)
- ☐ My sleep is moderately disturbed (2-3 hours sleepless). (3)
- ☐ My sleep is greatly disturbed (3-5 hours sleepless). (4)
- ☐ My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all. (0)
- ☐ I am able to engage in all my recreation activities, with some pain in my neck. (1)
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- ☐ I can hardly do any recreation activities because of pain in my neck. (4)
- ☐ I cannot do any recreation activities at all. (5)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Hembree Chiropractic
Dr. Sean C. Hembree, DC
4304 SW Green Oaks Blvd., Ste. 150
Arlington, TX 76017
(817) 583-8266

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPPA"), I HAVE CERTAIN RIGHTS TO PROVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

1. CONDUCT, PLAN, AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTH CARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY OR INDIRECTLY.
2. CONDUCT NORMAL HEALTH CARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ, AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICE FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS ABOVE TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OF HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT NAME: ____

RELATIONSHIP TO PATIENT: ____________________________________

SIGNATURE: ____

DATE: ____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT I WAS UNABLE TO DO SO.

DATE: ______________ INITIALS: ________________ REASON: ______________________________

Hembree Chiropractic
Dr. Sean C. Hembree, DC
4304 SW Green Oaks Blvd., Ste. 150
Arlington, TX 76017
(817) 583-8266

CONSENT TO CHIROPRACTIC SERVICES

I, ______________________________, authorize the performance upon myself for chiropractic to be performed by or under the direction of Dr. Sean C. Hembree, DC. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure(s) has been given by the above doctor or his assistants.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Sean C. Hembree, DC, to release information related to all treatment and care on my behalf to other medical and health care professionals as deemed necessary.

I hereby authorize Hembree Chiropractic, Dr. Sean C. Hembree, DC, and any of his assistants to discuss my medical and financial information with the following people:

Name: ______________________________ Relationship: ____________

Phone: ____________ Address: ______________________________

Name: ______________________________ Relationship: ____________

Phone: ____________ Address: ______________________________

Name: ______________________________ Relationship: ____________

Phone: ____________ Address: ______________________________

____
Printed Name of Patient

______________________________ ____________
Signature of Patient Date

______________________________ ____________
Signature of Representative (if patient is a minor or disabled) Date

______________________________ ____________
Witness to Patient's Signature Date

Hembree Chiropractic
Dr. Sean C. Hembree, DC
4304 SW Green Oaks Blvd., Ste. 150
Arlington, TX 76017
(817) 583-8266

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Hembree Chiropractic

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand and am informed that, just like in any type of practice, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, or sprains. I do not expect the provider(s) to be able to anticipate and explain all risks and complications and I wish to rely on the provider(s) to exercise judgment during the course of treatment to procedure(s) which seems best at the time, based upon the facts then known, is in my best interest.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had the opportunity to discuss the nature, purpose, and risk of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

____
Printed Name of Patient

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Signature of Representative (if patient is a minor or disabled) Date

______________________________ ______________________
Witness to Patient's Signature Date

Hembree Chiropractic
Dr. Sean C. Hembree, DC
4304 SW Green Oaks Blvd., Ste. 150
Arlington, TX 76017
(817) 583-8266

FINANCIAL AGREEMENT

I understand that all payment for services is due at the time services are rendered. Payment may be made via cash, personal check, or credit/debit card. All major credit cards are accepted.

I understand that Hembree Chiropractic does not bill any third-party payer (i.e. insurance company) on my behalf and that I am expected to pay the full amount of all services rendered at the time of service. If I wish to be reimbursed through a third-party payer, I understand that I will need to notify Hembree Chiropractic each visit so that the proper documentation can be provided at the conclusion of my visit.

I understand that Hembree Chiropractic will, at my request, provide any of my records. I understand that this request may incur a $25 record request fee.

I understand that Hembree Chiropractic will accept my personal check made out to Dr. Sean C. Hembree. I also understand that there will be a $25 fee for any returned checks. Hembree Chiropractic reserves the right to no longer accept personal checks after a check has been returned.

I understand that it is my responsibility to notify Hembree Chiropractic if I am running late or unable to make a scheduled appointment for any reason. If I do not show up for an appointment and have failed to notify Hembree Chiropractic in a timely manner, I understand that I may be charged a $25 missed appointment fee.

I agree to pay all reasonable fees of attorneys and/or collection agencies needed to affect collection of any delinquent charges outstanding on my account. I also agree that if at any time there is need for legal action to be brought against any insurance company on my behalf, I will be responsible to instigating such action.

Sign only after you understand and agree to the above.

____
Printed Name of Patient

_______________________________________ _______________
Signature of Patient Date

_______________________________________ _______________
Signature of Representative (if patient is a minor or disabled) Date

_______________________________________ _______________
Witness to Patient's Signature Date