

CONFIDENTIAL PATIENT INFORMATION

Huskey Chiropractic

3820 E. 51st, Suite A

Tulsa, OK 74135

(918) 747-0939

DATE _____

If your injuries are due to an auto accident or work related accident please see front desk for appropriate paperwork.

NAME: _____ SS#: _____
LAST FIRST MI

ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____

BIRTHDATE: _____ () MALE () FEMALE () SINGLE () MARRIED () DIVORCED () WIDOWED

EMPLOYER: _____ PHONE: _____

SPOUSE'S NAME: _____ DOB: _____ SPOUSE'S SS#: _____

SPOUSE'S EMPLOYER: _____ EMPLOYER PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

Due to HIPPA regulations we will not discuss financial or medical records with anyone but our patient. If you would like to give our office authorization to discuss financial and/or medical records with your spouse or any other party please list their name and relation: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

NAME OF PRIMARY CARE PHYSICIAN: _____ PHONE: _____

Routine correspondence concerning your condition is sent to your PCP unless you advise otherwise.

PERSONAL HEALTH INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO.: _____ ID#: _____

EMPLOYER: _____ GROUP#: _____ DATE OF INJURY: _____

PRIMARY INSURED NAME: _____ SS#: _____ DOB: _____

ARE YOU REQUIRED TO HAVE A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN? YES ___ NO ___

NAME OF SECONDARY INSURANCE CO.: _____ ID#: _____

EMPLOYER: _____ GROUP#: _____

PRIMARY INSURED NAME: _____ SS#: _____ DOB: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient / Guardian Signature: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer.

Patient / Guardian Signature: _____

(over)

1. Please describe your area(s) of complaint. _____

2. How did this condition develop? (What caused it?) _____

3. On what date did your condition begin? _____

4. Have you ever had this problem or similar problems before? Yes No If yes, please explain: _____

Does your problem wake you from a sound sleep? Yes ___ No ___

Do you have numbness or tingling? Yes ___ No ___

Does your problem get worse while lying down? Yes ___ No ___

Do you have loss of bladder control? Yes ___ No ___

Have you recently had fever, sweats or chills? Yes ___ No ___

Do you have diabetes? Yes ___ No ___

Do you have a thyroid problem? Yes ___ No ___

Do you suffer from depression? Yes ___ No ___

Do you have dizziness? Yes ___ No ___

Do you have heartburn/indigestion? Yes ___ No ___

Do you have high blood pressure? Yes ___ No ___

Do you have painful urination? Yes ___ No ___

Have you been diagnosed with rheumatoid arthritis? Yes ___ No ___

Do you have noises in your ears? Yes ___ No ___

Do you have blurred or double vision? Yes ___ No ___

What activities do you find difficult to do because of this problem? _____

ARE YOU PREGNANT?

YES NO

PLEASE CHECK (✓) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

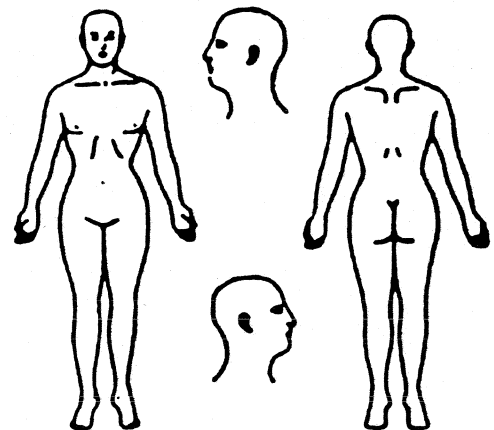
NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

MUSCULO-SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Disc problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Muscle spasms
- Broken bones
- Shoulder pain
- Carpal Tunnel

Please mark areas of pain on the figures below.



P ___ Pain
N ___ Numb

C ___ Cold Sensation
S ___ Spasm

HOW BAD IS THE PAIN
None 1 2 3 4 5 6 7 8 9 10 Severe