NEW PATIENT INTRODUCTION

(please print clearly)

Today's Date___________

Name____Age______Date of Birth____/____/____

Address__________________________________City____________State_________Zip________

Home #______________Work #_______________Cell #_____________ ❑ Single ❑ Married

Occupation____________________________Employer___________________________________

Referred by____________________________Previous Chiropractic Care (yes) (no)

Where_________________________________When_____________________________________

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED

UNLESS OTHERWISE ARRANGED

CONFIDENTIAL PATIENT INFORMATION

Huskey Chiropractic
Dr. Rick Huskey • Dr. Chandler Huskey
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: ____________________ EMAIL: ____________________________________

( )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#: __________________________

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: ___
____

What activities make your condition/s feel better? ______________________________
What activities make your condition/s feel worse? ______________________________
What activities do you find difficult to do because of this problem? _______________
____

Describe your pain: ( ) Sharp ( ) Dull ( ) Burning ( ) Ache ( ) Shooting ( ) Deep & Boring
Frequency of your pain: ( ) Occasional 0-25% ( ) Intermittent 26-50% ( ) Frequent 51-75% ( ) Constant 76-100%
Is your pain better in ( ) a.m. or ( ) p.m.?
Are your symptoms: ( ) Getting better ( ) Getting worse ( ) Staying the same

Have you taken medication for this current condition? Yes ___ No ___ Rx ______________
Does your problem wake you from a sound sleep? Yes ___ No ___
Do you have numbness or tingling? Yes ___ No ___ Where ______________
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 ___

ARE YOU PREGNANT?
❑ YES ❑ NO

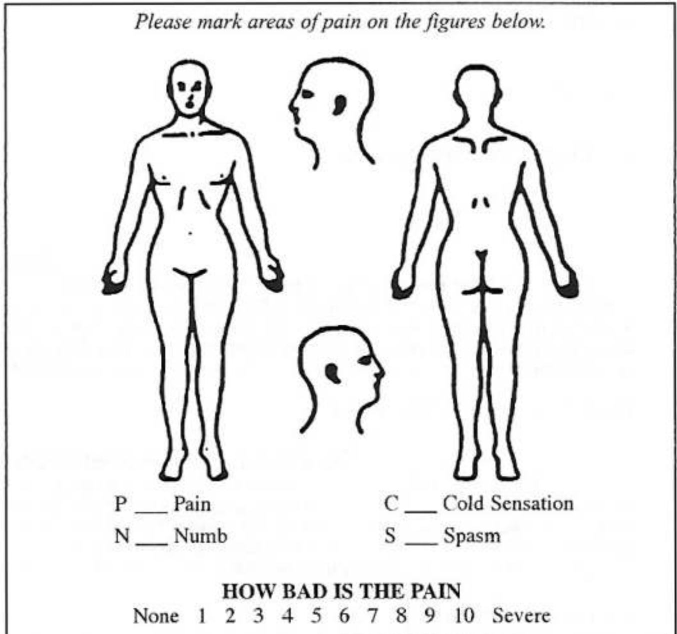
HAVE YOU SEEN ANOTHER CHIROPRACTOR
❑ YES ❑ NO

If yes, Whom?______________________
When?______________________

PLEASE CHECK (✔) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

NERVOUS SYSTEM
- ❑ Numbness
- ❑ Loss/Increased sensation
- ❑ 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
- ❑ Stiff & painful joints
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Muscle spasms



Name ____ Date ______________________________

Ethnicity _______ Hispanic/Latino ________ Non-Hispanic/Non-Latino

Race: _____ American Indian _____ Alaskan Native _____ Asian _____ African American/Black

_____ Native Hawaiian _____ Caucasian/White

Smoking Status: _____ Yes _____ No Frequency _____________ Quit?/When ___/___/___

No known Drug Allergies or List Allergies : ____

____

____

No Medications or List of Medications : ____

____

____

____

Family History and indicate the relationship:	Father	Mother	Sister	Brother
Anxiety _____	_____	_____	_____	_____
High Blood Pressure _____	_____	_____	_____	_____
Cancer/What Kind _________________________	_____	_____	_____	_____
Depression _____	_____	_____	_____	_____
COPD ______	_____	_____	_____	_____
Heart Disease/Attack ______	_____	_____	_____	_____
Diabetes ______	_____	_____	______	_____
Headaches/Migraines ______	_____	_____	_____	_____
Arthritis ______	_____	_____	_____	_____
Scoliosis ______	_____	_____	_____	_____

Huskey Chiropractic
Dr. Rick Huskey * Dr. Chandler Huskey

3820 E. 51st St., Suite A
Tulsa, OK 74135

Notice of Receipt of Privacy Notice of Huskey Chiropractic

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Huskey Chiropractic Clinic, in force as of April 14, 2003 and that all of my questions have been answered to my satisfaction in language that I can understand.

______________________________	______________________________
Print Name of Individual	Signature of Individual
______________________________	______________________________
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship
Date Signed: ____________________	Witness: ____________________