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

WORKER'S COMPENSATION HISTORY

Dr. Rick Huskey
3820 E. 51st, Suite A
Tulsa, OK 74135

DATE ________________

NAME:____ SS#:______________________
LAST FIRST MI

ADDRESS:____ HOME PHONE: ______________

CITY:______________________________ STATE:________ ZIP:__________ CELL PHONE:______________

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

EMPLOYER:____ PHONE:______________________

OCCUPATION:______________________________________ SUPERVISOR:______________________

SPOUSE'S NAME:______________________________________ DOB:______________________

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:______________________

INJURY INFORMATION

Time and date of injury________ ❑ AM ❑ PM _____/_____/_____

Please explain in detail how your present injury occured?____

____

____

____

____

To whom was injury reported?______________________________ Phone______________________

Where did you feel pain immediately after the injury?____

Did **you** consult any other doctor? ❑ Yes ❑ No

If so, give doctor's name______________________________ ❑ D.C., ❑ M.D., ❑ D.O., ❑ D.D.S.

Did **employer** send you to doctor? ❑ Yes ❑ No

If so, give doctor's name______________________________ ❑ D.C., ❑ M.D., ❑ D.O., ❑ D.D.S.

Doctor's diagnosis ____

Did you return to work? ❑ Yes ❑ No If so, date returned to work______________________

Did you lose time from work? ❑ Yes ❑ No If so, date off work ______________________

Did another doctor take you off work? ❑ Yes ❑ No If yes, from______________to______________

Were you hospitalized? ❑ Yes ❑ No

What medications are you presently taking?____

____

Do any other diseases or accidents affect your employment? ❑ Yes ❑ No If so, explain ______________

____

In your work, do you have to favor any part of your body? ❑ Yes ❑ No If so explain ______________

____

Before the injury, were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities now restricted as a result of this accident? ❑ Yes ❑ No

If so, what work activities?____

Since the injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ The same?

Have you retained an attorney? ❑ Yes ❑ No

If so, name, address, & phone # ____

HEALTH QUESTIONNAIARE

PLEASE CHECK (✓) CONDITIONS YOU ARE CURRENTLY EXPERIENCING

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

GENITO-URINARY SYSTEM

- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

FEMALE

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Vaginal pain
- ☐ Breast pain
- ☐ Lumps on the breast

GASTRO-INTESTINAL SYSTEM

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Difficult swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting Blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble

NERVOUS SYSTEM

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

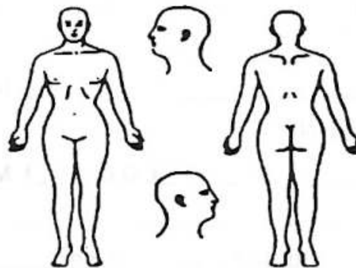
HABITS

- ☐ Cigarettes
- ☐ Alcohol Abuse
- ☐ Coffee or Tea
- ☐ Exercise
- ☐ Drug Abuse
- ☐ ____________________

ARE YOU PREGNANT?

☐ **YES** ☐ **NO**

Please mark your area of pain on the figure below.



P ____ **Pain** **N** ____ **Numb**

S ____ **Spasm**

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Most

CARDIO-VASCULAR RESPIRATORY

- ☐ Chest pain
- ☐ Pain over heart
- ☐ Difficult breathing
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Rapid heartbeat
- ☐ Blood pressure problems
- ☐ Heart problems
- ☐ Lung problems
- ☐ Varicose veins

EYE, EAR, NOSE AND THROAT

- ☐ Eye strain
- ☐ Eye inflammation
- ☐ Vision problems
- ☐ Ear pain
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Nose pain
- ☐ Nose bleeding
- ☐ Nose discharge
- ☐ Difficult breathing through nose
- ☐ Sore gums
- ☐ Dental problems
- ☐ Sore mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Sinus
- ☐ Allergy
- ☐ Jaw pain

	Y	N
Do you have diabetes?	☐	☐
Is problem worse while lying down?	☐	☐
Have you recently had fever, sweats, chills?	☐	☐
Does this problem wake you from a sound sleep?	☐	☐

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's Signature: ____________________

Parent's or Guardian's Signature: ____________________

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: ______________________