DR. DENNIS W. HARDING D.C., B.C.A.O.
ATLAS SPECIALIST

PATIENT INFORMATION

Name_____ Date of Birth _____ Age _____ Sex _____
Street _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work Phone _____ Ext. _____
Email _____ Height _____ Weight _____
Employer _____ Occupation _____
Spouse _____ Referred By _____ Soc Sec # _____
What is your major complaint? _____
How long have you had this condition? _____ Previously? Date _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? Y____ N____ Comes and goes _____
Is this interfering with your: Work_____ Sleep_____ Daily routine _____ Other _____
How long has it been since you really felt good? _____
Other complaints _____
List surgical operations _____
Are you taking any medications? _____
Other doctors seen for this condition? DC _____ MD _____ Other _____

INSURANCE

Company Name: _____ Policy # _____ Phone _____
Address _____ City/State/Zip _____
Insured's Name _____

ACCIDENT

Happened at Wk ___ Auto ___ Other _____
Date of Accident? _____
Where did injury occur? _____

WORKERS COMPENSATION

Employer notified? _____
Have you missed time from work? _____
Date last worked _____

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 have been informed in advance and in writing that Dr.Harding is not a participant in any HMO, health organization, or network associated with my health insurance company. 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's Signature _____ Date _____

1. I authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____

2. I authorize payment of medical benefits to Dr. Dennis W. Harding at Dennis W. Harding Professional Chiro. Corp. for services rendered.

Signed _____ Date _____

Dr. Dennis W. Harding D.C., B.C.A.O.
11899 Edgewood Road, Suite D | Auburn, CA 95603
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www.atlasdr.com

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Name: _____ **Patient#** _____ **Date:**_____

Important: Please check (X) all present symptoms

HEAD & BRAIN STEM:
- _____ Brain Fog
- _____ Memory Loss
- _____ Light Headedness
- _____ Fainting
- _____ Light Bothers Eyes
- _____ Blurred Vision
- _____ Double Vision
- _____ Loss of Balance
- _____ Dizziness
- _____ Ringing in Ears
- _____ Nervousness
- _____ Irritability
- _____ Depression
- _____ Fatigue
- _____ Loss of Sleep
- _____ Nausea
- _____ Constipation
- _____ Diarrhea
- _____ Seizure
- _____ Loss of Hearing
- _____ Loss of Taste
- _____ Loss of Vision
- _____ Nervous Stomach
- _____ Headache
- _____ Migraine
- _____ Head Feels Heavy
- _____ TMJ/jaw pain

NECK:
- _____ Pain in Neck
- _____ Neck Pain with Movement
- _____ Pinched Nerve in Neck
- _____ Neck Feels out of Place
- _____ Muscle Spasms in Neck
- _____ Grinding/Popping in Neck
- _____ Arthritis in Neck

SHOULDERS:
- _____ Pain in Shoulder Joint (R-L)
- _____ Pain Across Shoulders
- _____ Bursitis (R-L)
- _____ Arthritis (R-L)
- _____ Can't Raise Arm
  - ____ Above Shoulder Level
  - ____ Over Head
- _____ Tension in Shoulders
- _____ Muscle Spasm

ARMS & HANDS:
- _____ Pain in Upper Arm
- _____ Pain in Elbow
- _____ Tennis Elbow
- _____ Pain in Forearm
- _____ Pain in Hands
- _____ Pain in Fingers
- _____ Pins & Needles in Arms
- _____ Pins & Needles in Fingers
- _____ Numbness in Arms (R-L)
- _____ Numbness in Fingers (R-L)
- _____ Fingers go to Sleep
- _____ Hands Feel Cold
- _____ Swollen Joints in Fingers
- _____ Sore Joints in Fingers
- _____ Arthritis in Fingers
- _____ Loss of Grip Strength

MID-BACK:
- _____ Mid Back Pain
- _____ Pain Between Shoulder Blades
- _____ Sharp Stabbing
- _____ Dull Ache
- _____ Pain from Front to Back
- _____ Muscle Spasms
- _____ Pain in Kidney Area
- _____ Rib Pain

LOW BACK:
- _____ Low Back Pain
- _____ Low Back Pain is worse when:
- _____ Working
- _____ Lifting
- _____ Stooping
- _____ Standing
- _____ Sitting
- _____ Bending
- _____ Coughing
- _____ Lying Down (Sleeping)
- _____ Walking
- _____ Low Back Feels Out of Place
- _____ Pain Relieves When_____

_____

CHEST:
- _____ Chest Pain
- _____ Shortness of Breath
- _____ Breast Pain

HIPS, LEGS & FEET:
- _____ Pain in the Buttocks (R-L)
- _____ Pain in Hip Joint (R-L)
- _____ Pain Down Leg (R-L)
- _____ Knee Pain
- _____ Leg Cramps
- _____ Cramps in Feet (R-L)
- _____ Pins & Needles in Legs
- _____ Numbness of Leg (R-L)
- _____ Numbness of Feet (R-L)
- _____ Numbness of Toes
- _____ Feet Feel Cold
- _____ Swollen Ankles (R-L)

WOMEN:
- _____ Cramping
- _____ Irregularity

MEN:
- _____ Urinary Frequency
- _____ Difficulty in Starting
- _____ Night Urination

GENERAL:
- _____ Loss of Weight ___ lbs
- _____ Gain of Weight ___ lbs
- _____ Coffee ___ Cups/Day
- _____ Tea ___ Cups/Day
- _____ Cigarettes ___ Pack/Day
- _____ Diabetes
- _____ Hypoglycemia
- _____ Gas
- _____ Other

_____

_____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please read this entire document prior to signing it. It is important that you understand all the information presented in this document. Please feel free to ask any questions you might have before you sign this document.

Summary of Consent: I (The Patient) understand that I am hereby consenting to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, diagnostic x-rays, and any and all other necessary manipulations performed on my person by Dr. Dennis W. Harding and/or other licensed doctors of chiropractic who now or in the future work at his office. Dr. Dennis W. Harding has verbally discussed with me the nature and purpose of chiropractic adjustments, as well as the possible risks involved. I understand that results are not guaranteed.

Exposure to Treatment: I understand and am informed that there are some assumed risks in receiving chiropractic treatments, as with any Healthcare procedure I might undertake. The possible risks specifically from chiropractic are considered rare or extremely rare and can include, but are not limited to: temporary soreness, increased symptoms, disc herniation, dizziness, stroke, fractures, or nausea. Given the nature of the Upper Cervical Atlas Orthogonal method which Dr. Harding practices, these symptoms/risks are exceedingly more remote than with traditional chiropractic adjustments.

Screening: Dr. Harding will make every reasonable effort during the examination to screen for possible contraindications to care; however, I understand that it is my responsibility to inform Dr. Harding of any condition that would otherwise not come to his attention.

Risks From Lack of Treatment: I am also informed of the risks and adverse effects which may occur from remaining untreated (no chiropractic care). Some of these adverse effects of a lack of treatment may be, but are not limited to: the formation of adhesions, reduced mobility, increased pain, more complicated future treatment and potentially longer future treatment.

Consent: I, _____ have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed any and all concerns with Dr. Dennis W. Harding and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended by Dr. Dennis Harding. Having been informed of the risks, I hereby give my full consent to treatment.

Dated: _____

Patient's Name (print): _____

Patient's Signature: _____

Parent Signature: _____
(If patient is a minor)

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SECTION 8: NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT INITIAL USES AUTHORIZATION FORM

Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Dennis W. Harding Professional Chiropractic Corp. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy offical, Jennifer Andrasz.

Dennis W. Harding Professional Chiropractic Corp. also used protected health information for internal referral boardand testimonials (you may opt out of this authorization). _____ (please initial)

If you have any questions regarding this notice of our health information privacy policies, please contact: Jennifer Andrasz

You can reach the Privacy Offical at: Dennis W. Harding Professional Chiropractic Corp., 11889 Edgewood Rd., Ste. D, Auburn, CA 95603, (530) 823-3734. Hours available: a message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email Address: _____(you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative:_____

Relationship of Personal Representative:_____

Date of Signature:_____

_____

Staff complete only if NO signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

❑ Patient refused to sign this acknowledgement even though patient was asked to do so and the patiend was given the Notice of Privacy Practices

❑ Other: _____

Staff Signature: _____Date: _____