

## 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.

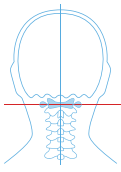
Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

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 \_\_\_\_\_



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:**

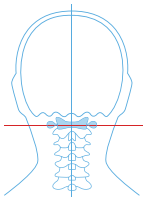
- \_\_\_ Cramping
- \_\_\_ Irregularity

**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
- \_\_\_\_\_
- \_\_\_\_\_



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

ATLAS SPECIALIST

## 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)

Dr. Dennis W. Harding D.C., B.C.A.O.

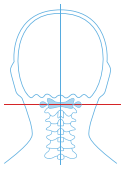
**Dr. Dennis W. Harding D.C., B.C.A.O.**

11899 Edgewood Road, Suite D | Auburn, CA 95603

Ph: 530-823-3734

Fax: 530-823-5432

www.atlasdr.com



## **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 official, Jennifer Andrasz.

Dennis W. Harding Professional Chiropractic Corp. also used protected health information for internal referral board and 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 Official 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 patient was given the Notice of Privacy Practices

Other: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_