

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.

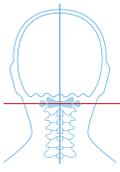
Patient's Signature _____ Date _____

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:

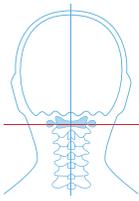
- ___ Cramping
- ___ Irregularity

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.

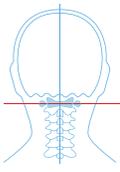
Dr. Dennis W. Harding D.C., B.C.A.O.

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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 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: _____