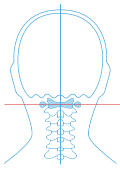


DR. DENNIS W. HARDING D.C., B.C.A.O.
ATLAS SPECIALIST

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 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.

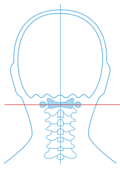
Signed____ Date________________

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

Ph: 530-823-3734
Fax: 530-823-5432
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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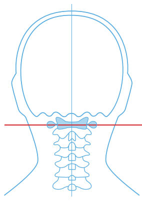

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

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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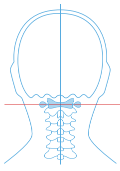

SECTION 8: NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT INITIAL USES AUTHORIZATION FORM

Effective: 4-15-2003

By signing this form, you acknowledge that you were offered 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 available 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.

You can reach the Privacy Official at: Dennis W. Harding Professional Chiropractic Corp., 11889 Edgewood Rd., Ste. D, Auburn, CA 95603, (530) 823-3734. 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 acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

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

❑ Other: ____

Staff Signature: ____Date: ____________________________