HARKEY CHIROPRACTIC, LLC

Accident Information

PATIENT INFORMATION							
Last Name		First		M.I.	Date		
Street Address				Apartment/Unit #			
City		State		ZIP			
Home Phone		Cell Phone					
Work Phone		Social Security #		Date of Birth			
Age		Sex	M F	Marital Status (circle one)	Married, Single, Divorced, Widowed		
E Mail address							

EMERGENCY CONTACT			
Name		Address	
Relationship			
Home Phone		Cell Phone	

MEDICAL INSURANCE INFORMATION (SKIP IF YOU HAVE AN ATTORNEY)			
Insurance Carrier		Id Card #	
Policy Holder		Policy Holder Date of Birth	
Policy Holder Employer		Policy Holder SSN	

HEALTH CONDITION (NOT RELATED TO ACCIDENT)			
Primary Care Doctor		Phone	( )
Are you wearing (Please Circle) Heel Lifts Sole Lifts Inner Soles Arch Supports			

CURRENT MEDICATION (List current medications)

PAST HEALTH HISTORY		
Have you seen a chiropractor before? Yes No	Name of Doctor:	Date of last visit:
Please list all childhood health conditions:		
Please list all adult health conditions:		
Please list all surgeries:		
Females Only (Please Circle)		
I am: Pregnant Not Pregnant Unsure		

PREVIOUS INJURIES AND DATE OF OCCURRENCE (NOT RELATED TO ACCIDENT)	
Back Injury	Head Injury
Broken Bones	Industrial Accident
Disability	Joint Injury
Fall (Severe)	Laceration (severe)
Fracture	Motor Vehicle Accident
Soft Tissue Injury	Other:

SOCIAL HISTORY	
Do you smoke / chew? No Yes I smoke/chew _____ per week	Do you drink? No Yes I drink _____ per week

FAMILY HEALTH HISTORY (check all that apply to your family)

Condition	Family Member	Condition	Family Member
☐ Arthritis		☐ Asthma-Hay Fever	
☐ Back Trouble		☐ Bursitis	
☐ Cancer		☐ Constipation	
☐ Diabetes		☐ Disc Problem	
☐ Emphysema		☐ Epilepsy	
☐ Headaches		☐ Heart Trouble	
☐ High Blood Pressure		☐ Insomnia	
☐ Kidney Trouble		☐ Liver Trouble	
☐ Migraines		☐ Neuralgia	
☐ Pinched Nerve		☐ Scoliosis	
☐ Sinus Trouble		☐ Stomach Trouble	

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care of treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature:_____ Date: _____

Doctor's Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PATIENT INFORMATION AUTOMOBILE ACCIDENT						
Last Name		First		M.I.	Date	
Date of Injury						
YOUR AUTOMOBILE INSURANCE (SKIP IF YOU HAVE AN ATTORNEY)						
Insurance Name		Address				
Phone						
Policy Holder Name		Policy #				
THIRD PARTY AUTOMOBILE INSURANCE (company responsible for paying the bill) **(SKIP IF YOU HAVE AN ATTORNEY)**						
Insurance Carrier		Address				
Policy Holder						
Claim Number		Phone				
Adjuster						
ATTORNEY INFORMATION						
Name		Phone				
Address						
ACCIDENT INFORMATION						
Vehicle Information						
☐ Car	☐ Van	☐ SUV	☐ Station Wagon	☐ Truck/Pick Up	☐ Large Truck	☐ Bus
☐ Driver	☐ Front Passenger	☐ Left Rear Passenger	☐ Right Rear Passenger	☐ Other		
☐ Stopped at an Intersection	☐ Stopping in Traffic	☐ Stopped at Stoplight	☐ Making Right Turn	☐ Making Left Turn	☐ Parked	☐ Proceeding along in Traffic
Time of Accident	am/pm	Vehicle Speed	mph			
Damage to vehicle	☐ Mild	☐Moderate	☐Totaled	☐To Be Determined		
You hit the other vehicle?	Yes No	The other vehicle hit you?	Yes No	Other?		
Visibility	☐ Poor	☐ Fair	☐ Good			
Road Condition	☐ Icy	☐ Wet	☐ Sandy	☐ Dark	☐ Clean & Dry	

Did you see the accident coming? Yes No	Were you braced for the impact? Yes No
Did you have your seatbelt on? Yes No	Did the passenger airbag deploy? Yes No
Did the driver airbag deploy? Yes No	Did the side airbag deploy? Yes No
Does your vehicle have a headrest? Yes No	Did the police show up at the scene? Yes No
If your vehicle had a headrest, what position was it in? ☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck	What direction was your head facing on impact? ☐ Forward ☐ Turned Right ☐ Turned Left
Was your body thrown? ☐ Forward ☐ Backward ☐ Left ☐ Right ☐ Can't remember	
Did you lose consciousness? Yes No if yes, for how long?	Was an accident report filled out? Yes No
Did your body strike the inside of your vehicle? Yes No if yes, Explain	

WHAT DID YOU DO AFTER THE ACCIDENT

Where did you go after the accident? ☐ Home ☐ Work ☐ Hospital ER ☐ Family Doctor

Were you taken by ambulance? Yes No Were you hospitalized? Yes No Were X-Rays taken? Yes No

Was lab work done? Yes No

What did the hospital recommend?
☐ No instructions ☐ See family doctor ☐ See Chiropractor ☐ See Orthopedist ☐ See Neurologist ☐ Prescription medication

What type of treatment did you receive? ☐ Medication ☐ Heat ☐ Cervical Collar ☐ Ice

Did treatment benefit you? Yes No | Are you still being treated by them? Yes No If no, date of last visit

RATE THE FOLLOWING (place number next to activity)

1. I can do without difficulty
2. I manage to do, but with pain
3. I cannot do at all, because of pain

____Dressing	____Preparing Meals	____Leaning	____Reclining	____Bending	____ Standing
____Grooming	____Eating	____Walking	____Kneeling	____Twisting	____Driving/Riding a motor vehicle
____Cleaning	____Going to the restroom	____Squatting	____Reaching	____Sitting	____Exercising
____Carrying small objects	____Carrying large objects	____ Carrying a brief case/purse	____Climbing Stairs		
____ Lifting weights off the floor	____ Lifting weights off a table	____Pushing objects while seated	____ Pushing objects while standing	____ Pulling objects while seated	____ Pulling objects while standing

RATE THE FOLLOWING (place number next to activity)

1. This area is not affected
2. My condition moderately restricts this
3. My condition prevents this

____Reading	____Hearing	____Speaking	____Writing	____Using a keyboard	____Seeing
____Sense of Touch	____Sense of Taste	____Sense of Smell	____Holding	____Pinching	____Sensory discrimination

Are you able to have a normal, restful night's sleep? Yes No | Are you able to participate in desired sexual activities? Yes No

Please check which most describes your symptoms prior to the accident:

☐ I have NOT had prior symptoms similar to my current complaint | ☐ My current complaint DID exist before, but had been dormant | ☐ My current complaint ALREADY existed and were worsened

Has your history contributed to your symptoms? Yes No Unsure

Doctors Notes:

HARKEY CHIROPRACTIC, LLC

Patient Information

Name: _____

Date: _____

SYMPTOMS LIST (please check all that may apply)

Head:
- ☐ Headache
  - ☐ Sinus (allergy)
  - ☐ Entire Head
  - ☐ Back of Head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
  - ☐ Frequent and Severe
- ☐ Head feels heavy
- ☐ Lightheadedness
- ☐ Fainting
- ☐ Face flushed
- ☐ Loss of memory
- ☐ Eye strain
- ☐ Eyes sensitive to light
- ☐ Blurred vision
- ☐ Loss of vision
- ☐ Loss of balance
- ☐ Pain in the ears
- ☐ Ringing in the ears R L
- ☐ Buzzing in the ears R L
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Sinus trouble

Neck:
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turning to the left
  - ☐ Turning to the right
  - ☐ Bending to the left
  - ☐ Bending to the right
- ☐ Pinched nerve in neck
- ☐ Neck feels "out of place"
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Arthritis in neck

Shoulders:
- ☐ Pain in shoulder joint
- ☐ Pain across shoulders
- ☐ Pain between shoulder blades
- ☐ Stiffness in shoulders R L
- ☐ Tension in shoulders R L
- ☐ Pinched nerve in shoulder R L
- ☐ Muscle Spasms in shoulder R L
- ☐ Unable to raise arm R L
  - ☐ Above shoulder level
  - ☐ Over head

Arms & Hands:
- ☐ Pain in the upper arm R L
- ☐ Pain in the elbow R L
- ☐ Tennis elbow R L
- ☐ Pain in forearm R L
- ☐ Pain in hands R L
- ☐ Pain in fingers R L
- ☐ Sensation of pins and needles (arms) R L
- ☐ Sensation of pins and needles (fingers) R L
- ☐ Numbness in arms R L
- ☐ Numbness in fingers R L
- ☐ Swollen joints in fingers
- ☐ Stiffness in fingers R L
- ☐ Loss of grip strength R L
- ☐ Cold hands

Mid-Back:
- ☐ Mid-Back pain
- ☐ Mid-Back stiffness
- ☐ Mid-Back muscle spasms
- ☐ Pain in kidney area

Chest:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around the ribs
- ☐ Breast pain
- ☐ Irregular heartbeat

Abdomen:
- ☐ Nervous stomach
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

Low Back:
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back pain is worse when:
  - ☐ Working
  - ☐ Lifting
  - ☐ Stooping
  - ☐ Standing
  - ☐ Sitting
  - ☐ Bending
  - ☐ Coughing
  - ☐ Lying down
  - ☐ Walking
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

Hips, Legs and Feet:
- ☐ Pain in buttocks R L
- ☐ Pain in hip joint R L
- ☐ Pain down the leg R L
- ☐ Leg cramps R L
- ☐ Knee Pain R L
  - ☐ inside
  - ☐ outside
- ☐ Leg Pins & Needles R L
- ☐ Leg Numbness R L
- ☐ Toe Numbness R L
- ☐ Feet Numbness R L
- ☐ Swollen ankles R L
- ☐ Swollen Feet R L
- ☐ Feet feel cold R L

Women Only:
- ☐ Menstrual pain
- ☐ Menstrual cramping
- ☐ Irregular period
- ☐ Abnormal discharge
- ☐ Tumors

Men Only:
- ☐ Urinary frequency
- ☐ Difficulty in starting urination
- ☐ Night urination
- ☐ Prostate pain/swelling

General:
- ☐ Anxiety
- ☐ Nervousness
- ☐ Irritable
- ☐ Difficulty in prolonged riding in a car
- ☐ Depression
- ☐ Fatigue
- ☐ Loss of weight
- ☐ Weight gain
- ☐ Excessive perspiration
- ☐ Pallor
- ☐ Tremors
- ☐ Confusion

HARKEY CHIROPRACTIC, LLC

Lien and Authorization Assignment of Claim

Harkey Chiropractic has promised to treat my condition on the understanding that their services will be paid out of any insurance benefits, judgment or settlement which may be payable to me. In exchange for Harkey Chiropractic's promise:

I assign to Harkey Chiropractic my insurance benefits, settlement or judgment proceeds, which are or shall become payable to me in an amount equal to their fee for treating me grant them a lien on those benefits or proceeds for the payment of their fee.

My attorney and insurance company are directed and ordered that when they have any money payable to me, they pay Harkey Chiropractic their fee for treating me before anyone else, including me, is paid anything.

I authorize Harkey Chiropractic to give my attorney and/or insurance company all of the information pertaining to my case that they request.

I do hereby agree to assign any and all right, title, or interest to my claim against my insurance company and/or attorney or any other third party for breach of contract and/or bad faith and refusal to pay the bills or claims submitted by Harkey Chiropractic.

I further agree to assist in and fully cooperate with Harkey Chiropractic and its attorney in their attempts to collect on their charges and services rendered to me for which my insurance carrier and/or attorney has refused to pay. I understand this lien is non-revocable.

I am responsible for paying Harkey Chiropractic's fee for treating me, and at any time they can demand that I pay all or part of the balance of their fee. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover. I also agree to pay all of Harkey Chiropractic's expenses to collect their fee, including a reasonable attorney's fee as well as 18% interest annually on the balance due beginning with the last date of service.

By this agreement, I bind myself, my heirs, executors, administrators and assigns to the benefits of Harkey Chiropractic, their heirs, successors and assigns.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Patient Signature: _____ **Date:** _____

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date
_____	
Date	

Informed Consent Form

Patient Name: _____ Date: _____

Provider: Jason Harkey, D.C.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination, tests, various modes of physical therapy and/or diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) which are recommended by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future render treatment to me, while employed by, work for, or at, the office, or at any other related office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature, purpose and any risks of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, paralysis and strains/sprains. do not expect the doctor to be able to anticipate and explain all risks and complications, and i wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

i have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, i state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which seek treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Practice Name and Address: HARKEY CHIROPRACTIC, LLC
429 NORTH MAIN ST
SUMTER, SC 29150

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date