Updated Patient Information

Date:_____

Patient Name:_____

Adress:_____

City:_____ State:_____ Zip_____

Occupation:_____

Employer: _____

Employer Address: _____

Spouse Name: _____

PHONE NUMBERS

Home: _____

Work:_____

Cell: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone number:_____

Updated Subjective Complaint Form

Please Print

1. Present Complaint(s) – Please be specific: _____

2. Explain how it happened and whether it is work, non-work related, auto accident or other: _____

_____

3. Symptoms have persisted for: ____hours ____1 day ____days ____weeks ____months ____years

4. Complaint(s)/Symptoms: ____come and go ____came on gradually ____came on suddenly

5. What makes your condition worse? ____nothing ____lifting ____trying to stand ____standing ____walking

____*sitting* ____*movement* ____*exercise* ____*inactivity* ____*work activities* ____*home activities* ____*other*

6. What makes your condition better? ____nothing ____lifting ____trying to stand ____standing ____walking

____sitting ____movement ____exercise ____inactivity ____work activities ____home activities ____other

7. Quality of your pain:____Deep/Dull ____Tight ____Spasm ____Sharp ____Numbness ____Stabbing ___other

8. Does this pain radiate? ____yes ____no; If yes, from where to where: _____

9. Pain Level: On a scale of 0-10, with 0 being you're pain fee and can function quite well, and 10 being you're in excruciating pain all the time, where would you rate the intensity of your pain? |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

0 1 2 3 4 5 6 7 8 9 10

No Pain Low Pain Moderate Pain Intense Pain

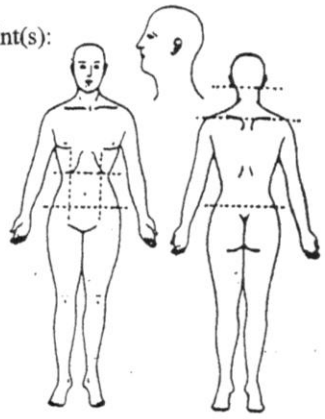
10. When did your complaint(s)/symptoms start? _____

11. Have you ever had this problem before? ____yes ____no; If yes, when? _____

12. Symptoms are **BETTER** in: ____AM ____Midday ____PM

Symptoms are **WORSE** *in:* ___AM ____Midday ____PM

13. Shade area(s) of your complaint(s):



14. What have you done to relieve your condition? _____

Patient Signature : _____ Date:_____

HENDERSON
Chiropractic & Sports Rehab, P.C.

1211 Office Park Drive • Oxford, Mississippi 38655
Phone: 662-236-2295 • Fax: 662-236-2215

Patient's Name:

Neuropathy Pain Scale

The following scales have been designed to find out about your complaint and how it is affecting you. Please answer ALL the scales by circling ONE number on EACH scale that best describes how you feel:

1. Please use the scale below to tell us how intense your pain is.

No pain — Most intense pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Please use the scale below to tell us how sharp your pain feels. Words used to describe "sharp" feelings include "like a knife," "like a spike," "jabbing" or like "jolts."

Not sharp — The most sharp pain imaginable

0 1 2 3 4 5 6 7 8 9 10

3. Please use the scale below to tell us how hot your pain feels. Words used to described very hot pain include "burning and "on fire."

Not hot — The most hot sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

4. Please use the scale below to tell us how dull your pain is. Words used to describe very dull pain include "like a dull toothache," "dull pain," "aching," and "like a bruise."

Not dull — The most dull sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

5. Please use the scale below to tell us how cold your pain feels. Words used to describe very cold pain include "like ice" and "freezing."

Not cold — The most cold sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

6. Please use the scale below to tell us how sensitive your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin" and "raw skin."

Not sensitive — Most sensitive sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

7. Please use the scale below to tell us how itchy your pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite."

Not itchy — The most itchy sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

8. Now that you have told us the different physical aspects of your pain, the different types of sensations, we want you to tell us overall how unpleasant your pain is to you. Words used to describe very unpleasant pain include "miserable" and "intolerable." Remember, pain can have a low intensity, but still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable. With this scale, please tell us how unpleasant your pain feels.

Not unpleasant at all — The most unpleasant sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

9. We want you to give us an estimate of the severity of your deep versus surface pain. We want you to rate each location of pain separately. We realize that it can be difficult to make these estimations, and most likely it will be a "best guess," but please give us your best estimate.

How intense is your deep pain?

No deep pain — The most intense deep pain sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

How intense is your surface pain?

No surface pain — The most intense surface pain sensation imaginable

0 1 2 3 4 5 6 7 8 9 10

10. Which of the following best describes the time quality of your pain? Please check only one answer.

( ) I feel a back ground pain all of the time and occasional flare-ups (break-through pain) some of the time.

Describe the background pain:_____

Describe the flare-up (break-through pain): _____

( ) I feel a single type of pain all the time- Describe this pain _____

( ) I feel a single type of pain only sometimes- Other times, I am pain free.

Describe this occasional pain: _____

Patient Signature:_____ Date:_____

Neuropathy Pain scale: From Galer BS, Jensen MP. Development and preliminary validation of pain measure specific to Neuropathic pain: The Neuropathic pain scale. Neurology. 1997;48(1):332-338. Reprinted with permission from Lippincott Williams & Wilkins.

Authorization to Release Medical Information

I am authorizing the following person(s) to have access to my medical records.

_____ _____(relationship)

_____ _____(relationship)

_____ _____(relationship)

NONE_____

Patient Signature _____ Date _____

Authorization to Contact Patient

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of to the individual's home.

I wish to be contacted in the following manner (check all that apply)

_____ Home Telephone: _____

- _____ okay to leave message with detailed information
- _____ leave message with call-back number only
- _____ leave appointment reminder information

_____ Work Telephone: _____

- _____ okay to leave message with detailed information
- _____ leave message with call-back number only
- _____ leave appointment reminder information

_____ Written Communication:

- _____ okay to mail to my home address
- _____ okay to mail to my home or work address
- _____ okay to fax to this number _____

_____ Other

- _____ okay to leave message on this cell phone number: _____

The Practice's Privacy Notice has been provided to me prior to my signing below. I have had a chance to ask questions and/or have concerns addressed. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Priactice to provide treatment ot me and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and had encouraged me to read the Privacy Notice carefully prior to my signing this consent. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice ahs already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I have read and understand the above statements, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Your Physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If this is a conflict for you, you have the right to use another Healthcare Professional.

Patient Signature: _____ Date: _____

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Permission to receive information regarding your services:

*please check all that apply

___Cell phone

Number :_____

Carrier:_____ (ex: cspire, Verizon at&t ect.)

*message and data rates may apply

___Email

Email address:_____

_____ _____

Signature Date