Heard Chiropractic Clinic

DUSTIN P. HEARD D.C., B.S., P.A.
105 Crackerbox Lane, Suite A
Hot Springs, AR 71913
Office: (501) 760-5039 • Fax: (501) 760-5165

PATIENT INFORMATION

Please Print Date: _____ / _____ / 20_____

Patient Name:		Minor: ☐ Yes ☐ No	
Responsible Party:			
Address:			
City:	State:	Zip:	Birthdate:
Home Phone:	Work Phone:	Sex: ☐ M ☐ F	/ /
Cell Phone:	Email Address:		
SS#:	Employer:		
Spouse:		Emergency #:	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			
Referred by: ☐ Yellow Pages ☐ Friend ☐ Family ☐ Doctor ☐ Other _____			
Reason for Visit:			
Previous Treatments for This Condition:			
Other Doctors Seen for This Condition:			
When Did Your Symptoms Begin? / /		☐ Came On Gradually	
Were You in an Accident? ☐ Yes ☐ No		Date of Accident / /	
If Yes: ☐ Auto ☐ Home ☐ W/C ☐ Other		Do You Have an Attorney? ☐ Yes ☐ No	
Attorney Name:		Phone:	

PLEASE FILL OUT ALL INFORMATION ON BOTH SIDES OF THESE TWO PAGES

Office Use Only

Patient Type: _____ Status: ☐ N ☐ A ☐ I ☐ C

Statement Type: (0) No Statement (1) Non-Itemized (2) Itemized
( ) No Letters ( ) No Dunning Minimum Pmt: _____

Diagnosis:		
Accident Type: ☐ Auto ☐ Other ☐ None	Injury Date: / / or ☐ Gradual	Date Disabled: / /
Symptoms Prev.: ☐ Yes ☐ No	Date Consulted: / /	Date Reabled: / /
Employment Related: ☐ Yes ☐ No	Disability: ☐ Full ☐ Partial ☐ None	Date X-Rayed: / /
Hospitalized: ☐ Yes ☐ No	Return to Work:	Date Discharged: / /

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Insurance: If you have insurance, we will be glad to process your insurance for you as a courtesy of this office.
Pay Arrangements: If you are not covered under insurance, arrangements can be made for services rendered.

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and
ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not covered by my insurance carrier.

I also direct this office to do all acts necessary to recover all or any part of these sums payable to me.

A copy of this signature is as valid as the original.

_____
Patient Signature - Please Sign

I attest that the above information is accurate to the best of my ability.

Parent or Guardian Signature

MEDICAL RELEASE AUTHORIZATION

Date _____

I _____ formally request that my medical conditions and/or medical records may be reviewed and/or requested by the following individuals or entities (parent, spouse, attorney, insurance company, etc).

1. _____

2. _____

3. _____

This is a binding contract until the patient to change the agreement submits a written request.

_____
Patient (must be 16 years old)

_____
Parent or Guardian

_____
Witness

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I Acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

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COMPLAINTS

Name: _____ Date: _____ / _____ / 200_____

A	**NECK OR CERVICAL SPINE**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Neck Pain and Soreness	A	B	C	D
B	Loss or Pain upon Movement	A	B	C	D
C	Shoulder Pain	A	B	C	D
D	Pain/Numbness/Tingling into Arm or Hand	A	B	C	D
E	Weakness in Arm or Hand	A	B	C	D
B	**MID-BACK OR THORACIC SPINE**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Mid-Back Pain	A	B	C	D
B	Rib or Chest Pain	A	B	C	D
C	**LOWER BACK OR LUMBAR SPINE**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Lower Back Pain or Soreness	A	B	C	D
B	Loss or Pain upon Movement	A	B	C	D
C	Pain into Legs, Knees, or Feet	A	B	C	D
D	Numbness/Burning in Legs or Feet	A	B	C	D
D	**OTHER COMPLAINTS**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Headaches	A	B	C	D
B	Visual Disturbances/Blurry Vision	A	B	C	D
C	Ringing or Buzzing in Ears	A	B	C	D
D	Nausea or Vomiting	A	B	C	D
E	Difficulty Breathing	A	B	C	D
F	Dizziness	A	B	C	D
G	Recent Weight Loss	A	B	C	D
H	Bowel or Bladder Dysfunction	A	B	C	D
E	**AGGRAVATED BY**	**NONE**	**MILD**	**MODERATE**	**SEVERE**
A	Coughing	A	B	C	D
B	Sneezing	A	B	C	D
C	Prolonged Sitting	A	B	C	D
D	Prolonged Standing	A	B	C	D
E	Prolonged Riding in a Car	A	B	C	D
F	Lying on Stomach	A	B	C	D

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HISTORY

Name: _____ Date: _____ / _____ / 200_____

Please Circle any of the following diseases you may have had:

A) GRP 1	B) GRP 2	C) GRP 3	D) GRP 4
A) Anemia	A) Diphtheria	A) Polio	A) Whopping Cough
B) Measles	B) Hypertension	B) Ulcer	B) Migraine Headache C)
C) Arthritis	C) Emphysema	C) Eczema	Gallbladder Disease D)
D) Smallpox	D) Chickenpox	D) Asthma	Tumor or Cancer
E) Pleurisy	E) Malaria	E) Colitis	E) Heart Disease
F) Stroke	F) Diabetes	F) Gout	F) Diverticulitis
G) Bursitis	G) Tuberculosis	G) Mumps	G) Rheumatic Fever
H) Pneumonia	H) Rheumatism	H) Hernia	H) Venereal Disease
I) Epilepsy	I) Osteoporosis	I) Typhoid Fever	I) Kidney Disease
J) Neuritis	J) Hypoglycemia	J) Scarlet Fever	J) Bowel Obstruction
K) Hay Fever	K) Encephalitis	K) Thyroid Disease	K) Alcoholism
L) Hepatitis	L) Meningitis	L) Shingles	L) Chemical Dependency

Others:
List _____

Are you pregnant? ☐ **Yes** ☐ **No**

Surgical History: Indicate the Year

A) Stomach	_____	F) Appendix	_____	J) Uterus	_____
B) Rectum	_____	M) Spinal	_____	K) Breast(s)	_____
C) Tonsils	_____	G) Colon	_____	L) Prostate	_____
D) Ovaries	_____	H) Thyroid	_____	Others:	_____
E) Gallbladder	_____	I) Hernia	_____		_____

Others Please List:

Family Health History:	**Father**		**Mother**
Father	( )	Good Health	( )
Age _____ Deceased ☐ Yes ☐ No	( )	Heart Disease	( )
	( )	Diabetes	( )
Mother	( )	Stroke	( )
Age _____ Deceased ☐ Yes ☐ No	( )	Cancer	( )
Others Please List:	( )	Gout	( )
_____	( )	Other	( )

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