Dr. James K. Humber, Jr. DC, BCO
Dr. Tyler Charette, DC, BCO
Chiropractic Orthospinologists

PATIENT DETAILED INFORMATION

Last Name First Name MI "Nickname"

Address DOB

City State Zip/Postal Code E-mail

Home Phone Cell Phone & Carrier Work phone SS # (Last 4)

Emergency contact Primary contact # Relationship to Patient

Marital Status:
Single Married Widowed Divorced

How did you hear about us?
- ☐ Word of mouth
- ☐ Drive by
- ☐ Facebook
- ☐ Google
- ☐ Practitioner Referral
- ☐ Class/Workshop

*If by word of mouth, whom may we thank for referring you to us? _____

Health Complaints

What is your PRIMARY complaint? _____
How long have you been experiencing this primary complaint? _____
Has this progressed over time? (worse/same/better)
What do you think caused your primary complaint?
_____
Advanced Imaging? MRI, CT, X-ray? _____
Prior Chiropractic care or Physical Therapy? _____
What movements or activities tend to increase your pain?
1. _____ 3. _____
2. _____ 4. _____
What movements or activities tend to decrease your pain?
1. _____ 3. _____
2. _____ 4. _____

Are there movements or activities you typically avoid?

1. _____ 3. _____
2. _____ 4. _____

What activities are you no longer doing that you would like to do?

1. _____ 3. _____
2. _____ 4. _____

Is there anything about your lifestyle that you think contributes to your pain?

_____

List any other secondary complaints you are currently experiencing. (in order of severity)

1. _____ 3. _____
2. _____ 4. _____

Stress and anxiety can cause or enhance your secondary complaints.

Do you feel that stress influences your pain? (Yes or No)

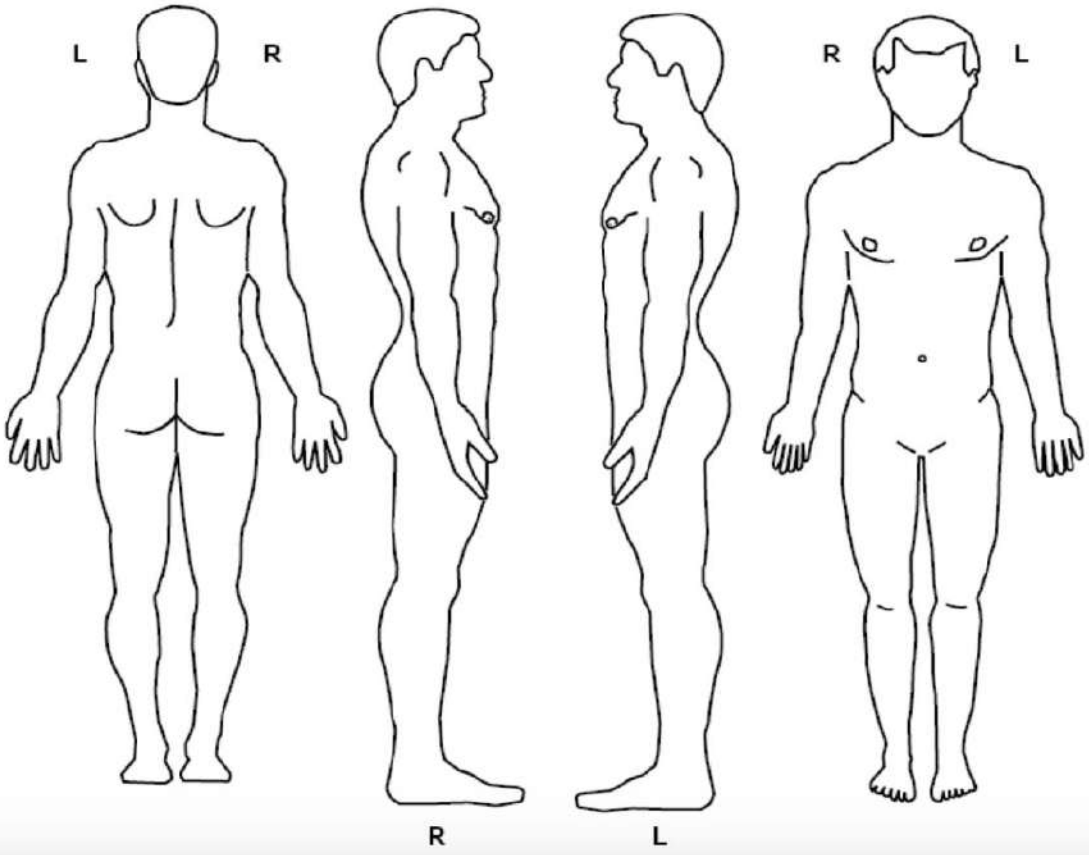
In the last 60 days, how often have you felt "stressed" or "overwhelmed"?

☐ Never Sometimes Fairly Often All the time

Do you feel that you manage your stress well? (Yes or No)

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness (N) **Tingling (T)** **Burning Pain (B)** **Stabbing Pain (S)** **Aching Pain (A)**



Lifestyle & Nutritional Habits

Occupational History:

Do you work? Yes No Disability Retired

Occupation(s):_____

Daily Habits:

On average, how many hours of television do you watch per day?

☐ <1 1-3 3-5 >5

On average, how many hours per day do you use a computer at work or at home?

☐ <1 1-3 3-5 >5

On average how many hours per day do you ride in a car or other vehicle?

☐ <1 1-3 3-5 >5

On average how many hours of sleep do you get per night?

☐ <6 7 8 >8

Do you exercise? (Yes) or (No)

If yes, how often?

☐ Daily 3-5x/wk. 2x/wk. 1x/wk.

If yes, how long are your workouts?

☐ < 0.5 hour 0.5-1hour 1-2hours >2 hours

What are your exercise activities? (mark all that apply)

- ☐ Walking
- ☐ Jogging/Running
- ☐ Swimming
- ☐ Biking
- ☐ Rowing
- ☐ Hiking
- ☐ Resistance Training
- ☐ Stretching
- ☐ Yoga/Pilates
- ☐ Intramural Sports

Do you smoke tobacco? (Yes or No) If yes, How often?_____How much?_____

Do you use recreational drugs? (Yes or No)

How many cups of water do you drink per day?

☐ 1-3 4-6 7-8 >8

How many servings of alcohol do you drink per week?

☐ 0 1-2 3-5 >5

How many cups of coffee do you drink per week?

☐ 0 1-2 3-5 >5

How many servings of soda do you drink per week?

☐ 0 1-2 3-5 >5

Dietary Habits:

Have you ever made changes in your eating habits due to your health? (Yes or No)

What does your diet primarily consist of? (mark all that apply)

- ☐ Breads & cereals
- ☐ Pastas & rice
- ☐ Lean Protein (chicken/fish)
- ☐ Red Meat
- ☐ Dairy (milk, cheese, etc.)
- ☐ Fruits
- ☐ Vegetables
- ☐ Healthy Fats
- ☐ Processed/packaged foods
- ☐ Cookies, crackers, pretzels
- ☐ Candy
- ☐ Soda/Energy Drinks

Family Health History

Mark the following conditions as they pertain to your family.
Include the family member. (Parents, Siblings, Children, Grandparents)

Diabetes _____
Heart conditions _____
Kidney conditions _____
Gastrointestinal issues _____
Autoimmune conditions _____
Respiratory issues _____
Musculoskeletal issues _____
Other _____

Cancer _____
Vascular Problems _____
(Including stroke)
Nerve conditions _____
(Neuropathies)
Neurological Conditions _____
(Parkinsons, MS, Dementia, etc)
Psychiatric Conditions _____

Do any family members have a condition that is similar to yours? (Yes or No)
If yes, please explain: _____

_____

Medical History

Mark any of the following conditions as they pertain to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-immune
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Myocardial Infarction
- ☐ Measles
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Psychiatric Disorders
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Whooping Cough

Any recent illnesses or infections? (if yes, explain): _____

_____

Any known allergies or sensitivities? _____
Number of Children? _____
List any broken bones or dislocations. (include location and date): _____
Have you suffered any head injuries? (including concussions): _____
Were you ever knocked unconscious? (if yes, please explain): _____

Surgical History

Do you have any implantable medical devices in your body? (including pacemakers, stents, plates, screws)
If yes, please explain: _____

Mark all of the following procedures as they pertain to you:

- ☐ Appendectomy
- ☐ Abdominal Surgery
- ☐ Cesarean Section
- ☐ Hernia Repair
- ☐ Thyroid Surgery
- ☐ Knee Replacement
- ☐ Hip Replacement
- ☐ Gall Bladder Removal
- ☐ Tonsillectomy
- ☐ Neurosurgery _____
- ☐ Spinal Surgery _____
- ☐ Cardiac Surgery _____
- ☐ Female Surgery _____
- ☐ Male Surgery

_____

Medications, Vitamins, Supplements

Please list any vitamins or supplements you are currently taking.

Please list any prescription or over-the-counter medications you are currently taking and the condition for which they are for.

Injuries

List any (even minor) motor vehicle collisions that you have been involved in as either a driver or passenger. Start with the most recent.

Type of Collision	Injury & Treatment Received	Date of Injury

List any athletic injuries that you have experienced below. Start with the most recent.

Type of Injury	Treatment Received	Date of Injury

List any other injuries that you have experienced below. .Start with the most recent.

Type of Injury	Treatment Received	Date of Injury

I understand and agree to the following:

It is my responsibility to complete the clinic's forms accurately and provide the most up to date information.

It is my responsibility to notify the doctor if any of the information has changed or requires updating.

Patient Name (print)	Patient Signature	Date

Parent/Guardian Name (print)	Parent/Guardian Signature	Date

HEALTH CARE AUTHORIZATION

As of April 14, 2003, the Federal Government requires a patient's signature to authorize being contacted by phone, mail, etc. This is a result of the Health Insurance Portability Act (HIPAA). The goal is to protect your personal health information.

PRINT PATIENT NAME _____
Last First Middle

Date of Birth _____/_____/ _____

Specific Authorizations:
I give permission for the Humber Clinic to contact me by e-mail, phone or leave message on my voice-mail regarding my appointments and status of health. I also give permission to use my name and address to mail office and e-mail newsletters, referral cards, postcards, holiday related cards or information about health related issues.

Initial Here: _____

Patient Rights:

1. **You have the right to refuse to sign this authorization.** If you refuse to sign this Authorization, the Humber Chiropractice Clinic will not refuse to provide treatment.

2. **You have the right to revoke this authorization, in writing at any time.** You may revoke this Authorization by mailing or hand delivering a written notice to the Privacy Official of the Humber Chiropractice Clinic. The written notice should contain your name, Social Security number and date of birth. State your intent to revoke this authorization, then sign and date it. Once received, the Privacy Official will revoke the authorization.

3. **You have the right to a copy of this authorization.**

Patient Signature_____**Date:** _____

Personal Representative Signature (if applicable) _____

For Office Use Only

Expiration-
This Authorization shall expire in 7 years. Expiration Date: _____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC

Chiropractic healthcare seeks to improve health through natural means without the use of drugs or surgery. This helps the body maximize its inherent healing ability. The success of the doctor of chiropractic's procedure often depends on underlying causes, patient compliance, as well as other spinal and physical conditions.

ADJUSTMENTS

The doctor utilizes the Grostic/Orthospinology Procedure, which is a low-force, non-rotary upper cervical (neck) technique. If adjustments to the lower spine are required, then the doctor will usually utilize a low-force, non-rotary adjustments, drop table, or handheld instrument.

INFORMED CONSENT FOR CHIROPRACTIC CARE

As a patient, you agree to give the doctor permission and authority to care for you in accordance with the chiropractic tests and analyses. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects of pathologies may render a patient susceptible to injury. The doctor will not provide healthcare if he is aware that such care may be contraindicated. Again, it is your responsibility to tell the doctor everything you know about your health conditions, which would otherwise not come to the attention of the doctor. The doctor of chiropractic provides a specialized, non-duplicating health service, but he is also available to work with other types of healthcare providers.

RESULTS

As a patient in this office, you are acknowledging that your doctor or his assistants have given no guarantee as to the results that may be obtained from you care. Chiropractic care is not a treatment of disease, but a system of correcting vertebral subluxations. The doctor also wants it understood that although he does not utilize rotary manipulation, he is in no way indicating that his procedure is superior to his fellow chiropractors.

AUTHORIZATION

In certain cases, it may be necessary for the doctor to discuss or send reports to other doctors, attorneys and/or other healthcare professionals for the sake of case management. As a patient, you are giving the doctor permission to use his best judgement for when to allow an observer in the room or when it is necessary to release the above patient information. I also give permission for the doctor to use information from my examination to help evaluate statistics for research, as long as my name is not used.

TO THE PATIENT

Please discuss any question or problems with the doctor before signing this statement of policy. I have had the above explained to me and after reading it, I understand the foregoing and give my consent. I acknowledge that the doctor reserves the right to discontinue and/or refuse care in the event that it becomes unsafe to render care or I become noncompliant with the current care plan.

Date_____Signature_____