

PATIENT INFORMATION

Name	Date of Birth	Age	Sex
Street	City	S	tateZip
Home Phone Ce	11	Work Phone	Ext
Email	Heig	ght	Weight
Employer	Occup	ation	
Spouse	Referred By		Soc Sec #
What is your major complaint?			
How long have you had this condition? What activities aggravate your condition?			
Is this condition getting progressively worse	? Y N	Comes and goes_	
Is this interfering with your: Work	_SleepDaily	routineC	Other
How long has it been since you really felt goo	od?		
Other complaints			
List surgical operations			
Are you taking any medications?			
Other doctors seen for this condition? DC_	MD	Ot	her
INSURANCE Company Name: Address Insured's Name	City/\$	State/Zip	
ACCIDENT Happened at WkAutoOther Date of Accident? Where did injury occur?	Have you missed	d? l time from work?	
I clearly understand and agree that all services repayment. I have been informed in advance that associated with my health insurance company. I a professional services rendered to me will be imm	Dr.Harding is not a part also understand that if I su	ticipant in any HMC uspend or terminate r), health organization, or network ny care and treatment, any fees for
Patient's Signature			Date
1. I authorize the release of any medical informa	tion necessary to process	s this claim.	
Signed			Date
2. I authorize payment of medical benefits to Dr. Der	nnis W. Harding at Dennis \	W. Harding Professiona	al Chiro. Corp. for services rendered



### Please check (X) all present symptoms ###################################	ame:	Patient#	Date:
Brain Fog Memory Loss Memory Loss Light Headedness Fainting Pain in Elbow Fain in Forearm Pain in Mads Pain in Forearm Pain in Forearm Pain in Forearm Pain in Forearm Phin & Needles in Arms Pain in Forearm Phin & Needles in Fingers Numbness in Fingers Pain in Forearm Pain in Forearm Phin Pain Ference (R-L) Pain Arms	portant: Please check (X) all present syr	nptoms	
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Memory Loss Light Headedness Tennis Elbow Breast Pain	Brain Fog	Pain in Upper Arm	Chest Pain
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Over Head Tension in Shoulders			
Tension in Shoulders			



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:

Dr. Dennis W. Harding D.C., B.C.A.O.

(If patient is a minor)



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 placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our Privacy Official.

You can reach the Privacy Official at: Dennis W. Harding Professional Chiropractic Corp., 11889 Edgewood Rd., Ste. D, Auburn, CA 95603, (530) 823-3734. Hours available: 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 E	Email Address:	(you may receive PHI through email	1)
Print F	Patient Name:		_
Signat	ture Patient/Personal Representative:		_
Relatio	onship of Personal Representative:		_
Date c	of Signature:		_
	omplete only if NO signature is obtained. If it is no made to obtain the individual's acknowledgment Patient refused to sign this acknowledgmen was given the Notice of Privacy Practices	, and the reasons why the acknowledgmen	nt was not obtained.
	Other:		
Staff S	Signature:	Date:	