Dr. Catherine Haikin, D.C.
2236 W Hefner Rd, Suite B
Oklahoma City, OK 73120

405-418-6418 phone
405-563-8695 fax
www.hefnerchiro.com

HEFNER CHIROPRACTIC

STATE OF THE ART. SCIENTIFIC. SPECIFIC.

Date: _____

Patient (First Name) _____ (Last Name) _____ Date of Birth: _____

Home Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work: _____ Cell: _____ Email _____

Social Security No. _____ No. of Children _____ Are you Pregnant? _____

Employer: _____ Employer Address _____

Marital Status: Single Married Divorced Widow/Widower Other ***(please circle one)***
Patient Gender: Male Female **(please circle one)**

If Under Age of 18: PLEASE LIST PARENTAL INFORMATION (and/or Legal Guardian Information)

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Name of Spouse: _____ Spouse's Phone Number: _____

Spouse's Employer: _____ Employer Address: _____

How did you learn of this clinic? _____
****(If referred by existing patient or other doctor, please list their name, so we may thank them properly)****
Nearest Relative not living with you: _____ Phone _____

Ethnicity: Hispanic or Latino/Other **Language** _____ **Smoking Status:** Every Day/ Some Days/ Former/ Never

Race: Asian/ African Am./Am.Indian or Alaskan Native/ Other/ Native Hawaii or Pacific Island/ White/ or _____

Who is responsible for payment? ____ Self ____ Spouse ____ Other: _____

Primary Insurance
Name of Insurance Co. _____
Claims Address _____
ID # _____
Group # _____
Policy Holder _____
Date of Birth of Policy Holder _____

Secondary Insurance
Name of Insurance Co. _____
Claims Address _____
ID # _____
Group # _____
Policy Holder _____
Date of Birth of Policy Holder _____

INSURANCE INFORMATION

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amo authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all servi rendered to 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 treatment, any fess for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Physician Signature: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-ray studies, laborat procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any par my(patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or emplo of the patient for all or part of the clinic's charger, including, and not limited to, hospital or medical service companies, insurance companies, work compensation carriers, welfare funds, or the patient's employer.

Patient Signature: _____ Physician Signature: _____

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Name: _____ Date: _____

What is your reason for being seen today in our office?

_____

_____

When did your pain begin? _____

Pain Level 1 2 3 4 5 6 7 8 9 10 *(Please Circle One)*

Is your condition: Getting Better Getting Worse

Is your condition: On & Off Constant

Type of Pain: Sharp Stabbing/Shooting Burning Achy Dull Deep Stiff Sore Numbness

Radiating To Area: Left / Right Base of Skull Shoulder Arm Hand Hip Leg Knee Foot Ribs Other: _____

_____

What makes it better? Ice Heat Rest Movement Stretching
Other: _____

What makes it worse? Sitting Standing Walking Sleeping Lying Down Bending Overuse
Other: _____

_____

Have you seen anyone else for this condition? YES NO
If yes, please list _____

Is this condition the result of an accident? (Auto, Fall, Work, Etc.) YES NO
If yes, please explain *(include date)* _____

_____

Allergies to Medications: NONE or Please List

_____

_____

Current Medications: NONE or Please List

_____

_____

(ALREADY HAVE A LIST? WE CAN MAKE A COPY TO KEEP ON FILE)

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 _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____
PRINTED

_____ _____
Signature **Date**

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