INITIAL HEALTH STATUS

Henderson Chiropractic

Please Tell us About Yourself...

Your Name:____________________
Address:____________________
City:__________ **State**:______ **Zip**:__________
Primary Phone: H W C ( ) ____________
Second Phone: H W C ( ) ____________
Your Email:____________________
Primary Physician:____________________
Primary Physician Phone: ( ) ____________
Sex: M / F **Age:**_____ **Birthdate:**__________
Social Security:__________ **Driver's Lic.:**__________
Marital Status: S / M / D / W **# of Children:**__________
Spouse's Name:____________________
Spouse's Employer:____________________
How Were You Referred to Our office?____________________

Please Describe Your Current Problem

What Brings You to Our Office Today? (circle one)

Chronic Recent Trauma Auto Related Work Related

O Headache O Neck Pain O Mid Back Pain O Low Back Pain

Other Area(s) of Complaint:____________________

When Did Your Problem Begin?:____________________
How Did Your Problem Begin?:____________________

Current Primary Complaint *(How do You Feel Today?)*

0 1 2 3 4 5 6 7 8 9 10

No Pain *(circle one)* *Unbearable Pain*

Of Your Day, How Often Are Your Symptoms Present?

O 0-25% *Occasional* **O** 25-50% *Intermittent* **O** 50-75% *Frequent* **O** 75-100% *Constant*

Should Your Bill be Handled Using... *(please circle)*

Cash **Credit** **Insurance**

Subscriber Name:____________________
Subscriber ID#:____________________
Group #:____________________
Health Plan:____________________
Your Occupation:____________________
Your Employer:____________________

DRAW YOUR PAIN

Please place the corresponding letter on the appropriate region on the diagram

D = Dull Ache
B = Burning
S = Sharp
SS = Shooting
N = Numbness
T = Tingling

IMPORTANT

O Recent Fever
O Chest Pain
O High Blood Pressure
O Steroid Use (Cortisone, Prednisone, etc.)
O Birth Control
O Dizziness / Fainting
O Numbness in Groin / Buttocks
O Pain at Night
O Menstrual problems

O Visual Disturbances
O Diabetes
O Osteoporosis
O Prostate Problems
O Urinary Problems
O Epilepsy / Seizures
O Abnormal Weight O Gain O Loss
O Marked Morning Pain / Stiffness
O Pain Unrelieved by Position or Rest

O Currently Pregnant, *# wks:*__________
O Stroke *(date):*__________
O Cancer / Tumor *(explain):*__________
____
O Surgeries:__________
____
O Medications:__________
____
O Other:__________

Certification & Assignment

Ownership of X-ray Films…

It is understood and agreed that payment to the Doctor for X-rays is for the examination of the film only. All X-ray negatives will remain the property of this office. X-rays are kept and maintained by this facility and may be viewed at any time while I am a patient at this office. It is also understood that at times an outside radiologist is used for additional evaluation of films taken in this office and films could at times be in transit between facilities.

Authorization for Care…

I certify that I and/or my dependent (s), have insurance coverage with__________________ and I assign directly to Timothy Henderson, DC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions provide by this office. I hereby authorize the doctors at Dr. Timothy Henderson office and whomever they may designate as their assistants to examine and administer treatment as they so deem necessary

Use of Information

Timothy Henderson, DC may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment of services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. It is also understood that consultation by outside healthcare professionals may be used in collaborative efforts to acertain diagnostic information regarding my condition and for this use is hereby approved .

Patient's Signature____________________ ***Date***__________

Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient

CHIROPRACTIC, ORTHOPEDIC, NEUROLOGICAL, RADIOLOGICAL & POSTURAL EVALUATION

EXAMINATION #___ *New/Re-Ex* **DATE:**________________

Name:________________________________

Primary Complaint

____

VITALS

BP:____ /_____

Pulse:________

Age:________

Ht.________

Wt.________

NEUROLOGICAL

Reflexes	L	R
Biceps		
Triceps		
Ext. Dig.		
Patell.		
Achilles		

Motor / Sensory

Motor		Sensory	
C5	L1	C5	L1
C6	L2	C6	L2
C7	L3	C7	L3
C8	L4	C8	L4
T1	L5	T1	L5
T2	S1	T2	S1

VISUAL, POSTURAL & GAIT EVALUATION

Patient Build:	1. Slim	2. Well Proportioned	3. Slightly Overweight	4. Obese	5. Morbidly Obese
Carriage Gait:	1. Normal	2. Slight Difficulty	3. Noticeable Difficulty	4. Extreme Difficulty	5. Unable to Walk
Patient Movements:	1. Normal	2. Restricted	3. Guarded	4. HFP + / -	5. Minor's Sign + / -
Antalgic Position:	1. Head L / R	2. High Shoulder L / R	3. Lumbar Lean L / R	4. High Ilium L / R	5. Bakody's Sign + / -

	Cervical ROM Norm	Deg.	Pain	Dorso-Lumbar ROM Norm	Deg.	Pain
Flexion	60			90		
Extension	50			30		
L. Rotation	80			30		
R. Rotation	80			30		
L. Lat. Flex.	40			20		
R. Lat. Flex.	40			20		

Pain: *1:Mild, 2:Moderate, 3:Severe, 4:Very Severe*

ORTHOPEDIC TESTS

Cervical-Dorsal

Max. Cerv. Comp.:________

Jackson's:________

Cerv. Distraction:________

Shoulder Depression:________

O'Donohue's:________

Allen's:________

Lumbo-Pelvic

Kemp's:________

SLR:________

Bechterew's:________

Patrick Fabere's:________

Yeoman's:________

Addl. Studies / Notes: ________________

Tenderness

C 1 2 3 4 5 6 7 Trap SOT Lev Scap Rhoms

T 1 2 3 4 5 6 7 8 9 10 11 12 ParaSpinals

L 1 2 3 4 5 QL Multifidus GM

P Rsi Lsi Sac R L Piriformis Psoas Hamstrings

DIAGNOSTIC HIERARCHY

CERVICAL REGION

Neurological

723.1	Cervicalgia
723.5	Torticollis
729.1	Fibromyalgia / Myalgia
780.4	Dizziness
782.0	Numbness
784.0	Headache
952.05	Injury to Nerves C5-C7

Structural

714.0	Rheumatoid Arthritis
715.0	Osteoarthritis
720.0	Ankylosing Spondylitis
722.0	I.V.D. Disorder w/o Myelopathy
722.71	I.V.D. Disorder w/ Myelopathy
722.4	Disc Degeneration
733.0	Osteoporosis
737.10	Kyphosis (acquired)
737.20	Lordosis (acquired)
739.1	Segmental Dysfunction
839.01	C1 Subluxation
839.02	C2 Subluxation
839.xx	Cx Subluxation

Functional

524.6	TMJ Syndrome
739.1	Cervical / Thor. Seg. Dysfunction
847.0	Cervical Sprain / Strain

THORACIC REGION

Neurological

724.1	Thoracic Pain
729.1	Myalgia
782.0	Numbness
953.4 I	Injury to Brachial Plexus
729.2	Intercostal Neuritis
353.0	Brachial Plexus Lesion or TOS

Structural

714.0	Rheumatoid Arthritis
715.0	Osteoarthritis
720.0	Ankylosing Spondylitis
722.11	I.V.D. w/o Myelopathy
722.72	I.V.D. w/ Myelopathy
722.51	Disc Degeneration
733.0	Osteoporosis
737.10	Kyphosis (acquired)
737.20	Lordosis (acquired)
739.2	Segmental Dysfunction
807.01	Rib Fracture
839.21	Thoracic Subluxation / III Defined Dislocation

Functional

739.2	Thoracic Seg. Dysfunction
847.1	Sprain / Strain Thoracic Region
739.8	Costovertebral Seg. Dysfunction

LUMBAR REGION

Neurological

724.2	Lumbalgia
724.3	Sciatica
724.4	Lumbosacral Radiculitis
724.5	Backache
729.1	Myalgia
782.0	Numbness / Tingling
953.5	Injury to Lumbosacral Plexus

Structural

714.0	Rheumatoid Arthritis
715.0	Osteoarthritis
720.0	Andylosing Spondylitis
722.10	I.V.D. w/o Myelopathy
722.73	I.V.D. w/ Myelopathy
722.52	Disc Degeneration
733.0	Osteoporosis
737.10	Kyphosis (acquired)
737.20	Lordosis (acquired)
739.3	Segmental Dysfunction
738.4	Spondylolisthesis (acquired)
839.20	Lumbar Subluxation
839.42	Sacroiliac Subluxation

Functional

739.3	Lumbar Segmental Dysfunction
847.2	Sprain / Strain Lumbar Region

SACRUM / PELVIS / HIP

Neurological

953.3	Injury to Sacral Root
953.5	Injury to Lumbosacral Plexus

Structural

715.06	Osteoarthritis, Pelvis
718.55	Ankylosis, Pelvis
724.6	Ankylosis, Sacrum
839.41	Coccyx Subluxation / III Defined Discloation
839.42	Sacrum Subluxation / III Defined Dislocation

Functional

739.4	Sacral Segmental Dysfunction
739.5	Pelvic Segmental Dysfunction
843.9	Sprain / Strain Hip

Hip

739.5	Hip Segmental Dysfunction
843.0	Hip Sprain
726.5	Hip Bursitis

ENVIRONMENTAL CODING

E-812.0	MVA-Driver
E-812.1	MVA Passenger
E-885	Fall
E-917	Striking Objects

HEADACHES

784.0	Headache
307.81	Tension Headache
346.0	Classical Migraine
346.2	Sinus/Cluster/Headache
625.4	Pre-Menstrual Headache
346.1	Common Headache

UPPER & LOWER EXTREMITIES

Shoulder

840.9	Shoulder Sprain/Strain
840.4	Rotator Cuff – Sprain
955.8	Shoulder Nerve Injury
739.7	Seg. Dysfxn. Upper Extremity
726.11	Calcific Tendonitis—Shoulder
726.0	Adhesive Capsulitis (Frozen Shldr.)
715.11	Shoulder Osteoarthritis
726.12	Bicipital Tenosynovitis
726.10	Rotator Cuff Syndrome/Bursitis

Wrist / Hand

842.xx	Wrist/Hand Strain/Sprain
354.0	Carpal Tunnel Syndrome
719.93	Forearm Inflammation
739.7	Seg Dysfxn. Upper Extremity

Elbow

841.xx	Elbow Strain/Sprain
726.31	Medial Epicondylitis
726.32	Lateral Epicondylitis (Tennis, Golfers)
719.42	Elbow Pain

Knee

844.0	Lat. Collateral Sprain/Strain
844.1	Med. Collateral Sprain/Strain
844.2	Cruciate Ligament Sprain/Strain
726.64	Patellar Tendonitis

Ankle / Foot

845.00	Ankle Sprain/Strain
845.10	Foot Sprain/Strain
719.47	Ankle-Foot Seg. Dysfxn.
726.73/728.71	Calcaneal Spur/Plant Fasciitis