



# Healing Hands Chiropractic, LLC

Tracy Malton, DC

3 Hall Ave ♦ Wallingford, CT 06492 ♦ 203-626-9994

## RE-EXAMINATION After Absence QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Our goal is to offer the very highest quality care possible. Please help us by responding to each question below.

### Complaint: # 1

Please enter the date this episode began: \_\_\_\_\_

Do you have a new injury or new area of complaint? Yes No

Flair up of old condition? Yes No

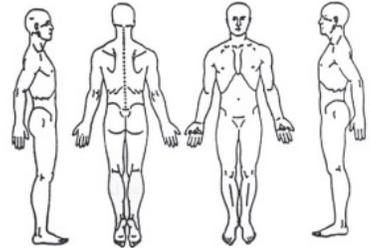
Auto accident or work comp injury? Yes No

Where does it hurt? \_\_\_\_\_

How often does it bother you? (please circle) Constantly 100%, 50-75%, 25-50%, occasionally 0-25%  
How does it feel? (Circle all that apply) acute, dull, aching, sharp, stabbing, numbness, tingling, discomfort, electric, burning, hot, cold Other: \_\_\_\_\_

Does it radiate?

- up/down arm L, R
- up/down leg L, R
- up/down neck/face L, R
- buttock L, R
- up/down back L, R



How did it begin? \_\_\_\_\_

- accident \_\_\_\_\_
- slip or fall
- long flight
- sleeping wrong
- lifting object \_\_\_lbs
- over reach/arching
- household chores
- yard work
- sitting too long
- chronic prolonged illness
- other \_\_\_\_\_

**Pain Assessment** reported as \_\_\_\_/10 with 0= none 10= worst

Is it aggravated by: (circle) movement, sitting, pushing, pulling, reaching, lifting, washing, sex, driving, walking, running, twisting, standing, other: \_\_\_\_\_

Relieved by: rest, ice, heat, meds, massage, chiropractic care, movement, other \_\_\_\_\_

Any other treatment received? \_\_\_\_\_

Does it keep you from doing any activity? (Please list i.e. work, sleep, playing with kids etc.) \_\_\_\_\_

NAME:

DATE:

### Complaint: # 2

Please enter the date this episode began: \_\_\_\_\_

Do you have a new injury or new area of complaint? Yes No

Flair up of old condition? Yes No

Auto accident or work comp injury? Yes No

Where does it hurt? \_\_\_\_\_

How often does it bother you? (please circle) Constantly 100%, 50-75%, 25-50%, occasionally 0-25%

How does it feel? (Circle all that apply) acute, dull, aching, sharp, stabbing, numbness, tingling, discomfort, electric, burning, hot, cold Other: \_\_\_\_\_

Does it radiate?

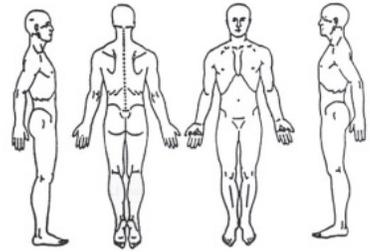
— up/down arm L, R

— up/down leg L, R

— up/down neck/face L, R

— buttock L, R

— up/down back L, R



How did it begin? \_\_\_\_\_

— accident \_\_\_\_\_

— slip or fall

— long flight

— sleeping wrong

— lifting object \_\_\_lbs

— over reach/arching

— household chores

— yard work

— sitting too long

— chronic prolonged

illness

— other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pain Assessment reported as \_\_\_\_/10 with 0= none 10= worst

Is it aggravated by: (circle) movement, sitting, pushing, pulling, reaching, lifting, washing, sex, driving, walking, running, twisting, standing, other:

\_\_\_\_\_

Relieved by: rest, ice, heat, meds, massage, chiropractic care, movement, other \_\_\_\_\_

\_\_\_\_\_

Any other treatment received? \_\_\_\_\_

\_\_\_\_\_

Does it keep you from doing any activity? (Please list i.e. work, sleep, playing with kids etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME:

DATE:

### Complaint: #3

Please enter the date this episode began: \_\_\_\_\_

Do you have a new injury or new area of complaint? Yes No

Flair up of old condition? Yes No

Auto accident or work comp injury? Yes No

Where does it hurt? \_\_\_\_\_

How often does it bother you? (please circle) Constantly 100%, 50-75%, 25-50%, occasionally 0-25%

How does it feel? (Circle all that apply) acute, dull, aching, sharp, stabbing, numbness, tingling, discomfort, electric, burning, hot, cold Other: \_\_\_\_\_

Does it radiate?

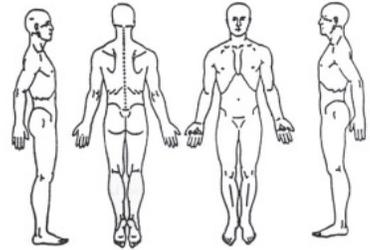
— up/down arm L, R

— up/down leg L, R

— up/down neck/face L, R

— buttock L, R

— up/down back L, R



How did it begin? \_\_\_\_\_

— accident \_\_\_\_\_

— slip or fall

— long flight

— sleeping wrong

— lifting object \_\_\_lbs

— over reach/arching

— household chores

— yard work

— sitting too long

— chronic prolonged illness

— other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pain Assessment** reported as \_\_\_/10 with 0= none 10= worst

Is it aggravated by: (circle) movement, sitting, pushing, pulling, reaching, lifting, washing, sex, driving, walking, running, twisting, standing, other: \_\_\_\_\_

Relieved by: rest, ice, heat, meds, massage, chiropractic care, movement, other \_\_\_\_\_

Any other treatment received? \_\_\_\_\_

Does it keep you from doing any activity? (Please list i.e. work, sleep, playing with kids etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAME:

DATE:

**Systems Review:** (since most recent evaluation). Please list any changes in your health:

- *Musculoskeletal:* Other than presenting musculoskeletal problems listed above, any new problems?

- *Neurological:* \_\_\_\_\_
- *Head & ENT:* \_\_\_\_\_
- *Cardiovascular:* \_\_\_\_\_
- *Respiratory:* \_\_\_\_\_
- *Gastrointestinal:* \_\_\_\_\_
- *Genitourinary:* \_\_\_\_\_
- *Endocrine:* \_\_\_\_\_
- *Dermatology./Hematology:* \_\_\_\_\_

**Past, Family and Social History:** (since initial evaluation)

- *Past Health History:* \_\_\_\_\_
  - *New Surgeries?* \_\_\_\_\_
  - *New Medications?* \_\_\_\_\_
  - *New Illnesses?* \_\_\_\_\_
  - *New Accidents?* \_\_\_\_\_
- *Family and Social History* \_\_\_\_\_
  - *Family History?* \_\_\_\_\_
    - *Work Habits?* \_\_\_40hrs\_\_\_ over40hrs \_\_\_/hr per week \_\_\_ Very physical \_\_\_ Mildly physical \_\_\_ Sedentary other \_\_\_\_\_
- *Social Habits:* Smoker Y / N \_\_\_ Packs/day \_\_\_ I just quit ☺ Alcohol \_\_\_ drinks/week \_\_\_
  - *Any changes to Exercise Habits?* \_\_\_ daily \_\_\_ 3X week \_\_\_ Occasional \_\_\_ never other: \_\_\_\_\_
  - *New Diet and Nutritional changes?* \_\_\_ Eating healthy \_\_\_ Eating poorly \_\_\_ Reduced calorie  
 \_\_\_ New diet (which type): \_\_\_\_\_
- Organic pain: Where: \_\_\_\_\_ How often? \_\_\_\_\_
  - Quality of pain? \_\_\_\_\_ How did it start? \_\_\_\_\_ gradual/sudden
  - Is it aggravated by movement? Y / N Other \_\_\_\_\_ Relieved by? \_\_\_\_\_
  - Any treatment received? \_\_\_\_\_

DO YOU HAVE ANY SUGGESTIONS FOR US? OR ANY TESTIMONIAL YOU WOULD LIKE TO GIVE:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME:

DATE:

# EZ-Pay Signature-On-File Authorization

I, \_\_\_\_\_, hereby authorize **Healing Hands Chiropractic, LLC** to initiate payments from my credit or bank account with the financial institution identified by me on this form for payment of services and/or products provided by **Healing Hands Chiropractic, LLC** not to exceed \$ \_\_\_\_\_ per transaction.

\_\_\_\_\_ (initial) I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **Healing Hands Chiropractic, LLC** in writing of any changes in my account information or termination of this authorization at least 15 days prior to any further charges to my credit card or bank account. I certify that I am an authorized user of this credit card/bank account and will not dispute these transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form. Notice to cancel can be given by either mailing to: 3 Hall Ave Wallingford, CT 06492 or faxing to: **203-284-3677**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CREDIT CARD** (last 4 digits) \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ (Circle One) VI, MC, AM, DI

Card Holder's Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACH BANK ACCOUNT** (last 4 digits) \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Bank Name: \_\_\_\_\_

Bank Account Holder's Name: \_\_\_\_\_

If ACH Transactions are rejected for Non Sufficient Funds (NSF) I understand that **Healing Hands Chiropractic, LLC** may at its discretion attempt to process the charge again within 30 days, and agree to any additional **\$25.00** charges for each attempt returned NSF which will be initiated as a separate transaction.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Billing Address Associated with Credit Card or Bank Account

Billing Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

NAME:

DATE:

### ***Treatment Disclaimer***

Is your treatment for any of the following? Please circle **YES/NO**

Worker's Comp    **Yes**    **No**

Personal Injury \*\* **Yes**    **No**

Auto accident \*\*    **Yes**    **No**

Auto Accident on Company time    **Yes**    **No**

Health & Wellness    **Yes**    **No**

Other ie: slip/fall    **Yes**    **No** (If **Yes**, please explain) \_\_\_\_\_

I understand that if at any time during my care at Healing Hands Chiropractic, LLC it is deemed as Worker's Compensation that HHC does not participate in Workers Comp. If my care is found to be Workers Comp. HHC will provide notes at an additional fee, but will not provide reports, scans etc.

\*\*Please note, If this is a **Personal Injury** or **Auto** case we require a Letter of Protection, Letter of Representation, Medical Authorization and Med Pay/Private Health Insurance **PRIOR TO CARE BEING GIVEN.**

\_\_\_\_\_

**Date** \_\_\_\_\_

**Patient Signature**

**PRE-SCAN** Checklist for: \_\_\_\_\_ Date \_\_\_\_\_

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

**Please let us know if we need to be mindful of the following:**



Drinking coffee or tea can excite the nervous system. Have you had any of these caffeinated beverages today?

No  Yes

About \_\_\_\_ cups.

Cola drinks contain caffeine and chemicals that can affect the nervous system.

How many sodas have you had today: \_\_\_\_\_.



Nicotine is a nervous system stimulant. Have you used any tobacco today?

No  Yes How much: \_\_\_\_\_

Common, over-the-counter drugs can impact the nervous system.

Have you taken any of these types of drugs today?

No  Yes \_\_\_\_\_



Many prescription drugs and muscle relaxers affect the nervous system.

Have you taken any type of prescription medication today?

No  Yes \_\_\_\_\_

Excessive exposure to the sun affects the accuracy of your scan.

Have you had a sunburn in the last five days?  No  Yes



Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.

Have you used any of these products today?  No  Yes

Vigorous physical activity can exaggerate your scan results.

Have you had a workout today?  No  Yes



Stress, depression, anxiety or emotional upsets can affect nervous system tension.

Compared to a typical day, are you currently experiencing an increased level of stress?  No  Yes