IDD Therapy Questionnaire - Patient Information

Please complete all pages as accurately as you can. If you need assistance please ask.
If possible, *please use a **blue ink pen** to make your form easier to read*.

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

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

E-mail: _____ Emergency contact: _____ Phone: _____

Social Security: _____ Drivers License: _____ State Issued: _____

Occupation: _____ Employer: _____ Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____ Date of Birth: _____/_____/_____

Do we have your permission to send you newsletters, reports and/or special offers via postal mail or e-mail?
☐ Yes ☐ No

How did you hear about Dr. Hardy?
☐ Referred by: _____ ☐ The Dixie Book ☐ The Local Book
☐ Spectrum Newspaper ☐ Dixie Weekly News ☐ Magazine Ad ☐ Radio ☐ Brochure ☐ Lecture ☐ Website

Females: Are you pregnant at this time? ☐ Yes ☐ No

Primary Care Doctor: _____ Date last seen: _____

Specialist: _____ Date last seen: _____

Do we have your permission to send your primary care doctor and/or specialist's a report of your findings and condition?
☐ Yes ☐ No

Please check additional healthcare professionals you are currently seeing or have seen in the past for this condition?
☐ Chiropractor ☐ Medical Physician ☐ Orthopedic Physician ☐ Neurologist ☐ Neurosurgeon
☐ Physical therapist ☐ Acupuncturist ☐ Massage therapist

Has any of the medical conditions below ever been diagnosed by a Medical Professional?

Please check off any of the following that you presently have or had in the past

☐ Herniated Discs
☐ Degenerated Disc Disease
☐ Posterior Facet Syndrome
☐ Sciatica
☐ General Low Back Pain
☐ General Neck Pain
☐ Numbness/tingling in the arm
☐ Numbness/tingling in the hand
☐ Numbness/tingling in the leg
☐ Numbness/tingling in the foot
☐ Spondylolysis
☐ Spondylolisthesis (grade 2 or higher)
☐ Severe Osteoporosis (T-Score of -2.5 to 2.8 or greater)
☐ Vertebral Fractures
☐ Unstable post surgical conditions
☐ Vertebral Fusions
☐ Instability of the spine
☐ Inflammatory Condition
☐ Infectious Condition
☐ Prostate and/or other types of Cancer
☐ Do you have any surgical hardware in your spine
☐ Do you have a heart pacemaker
☐ Unresolved Compression fractures on the spine
☐ Open Growth Plates
☐ Severe Canal Stenosis
☐ Rotary or Severe Scoliosis
☐ Abdominal Aortic Aneurysm
☐ Pacemaker
☐ Annular Tears

What is your present complaint?

□ Low Back Pain □ Neck Pain □ Sciatica □ Failed Back Surgery □ Other: _____

How long have you had this problem? □ Days □ Weeks □ Months □ Years
Is your problem getting? □ Better □ Worse □ Staying the same
Are you being treated for this condition by anyone else? □Yes □ No
(If yes, please feel out the following section below)

Name: _____ Specialty: _____

First visit date: ____/____/____ Last visit date: ____/____/____ How many treatments did you receive? _____

Did treatments benefit you? □ Yes □ Not much □ No

Types of treatments received: _____
_____

What are you hoping that we can do to help you? _____

_____

How soon would you be looking to take care of this problem? _____

_____

Imaging / Neurological Studies

What studies have been done in the past that relates to the condition you are in the office for today?

□ X-rays: Date: _____ □ MRI: Date: _____ □ CT: Date: _____
□ EMG: Date: _____ □ Other: Date: _____

Neck and/or Back Surgery

Please choose the best answers

Have you ever had spinal surgery ( ) Yes ( ) No	**Spinal Surgery Overall Results**
If Yes, please check off the number of surgeries	( ) I am better overall as the result of spinal surgery
( ) 1 operation ( ) 2 operations	( ) I am the same as I was before spinal surgery
( ) 3 operations ( ) 4 operations	( ) I am worse as the result of spinal surgery
( ) 5 operations ( ) more than 5 operations	
( ) I had spinal surgery in an area that doesn't apply to my current problem	

Type of Spinal Surgery **Dates of Spinal Surgery**

_____

_____

_____

_____

_____

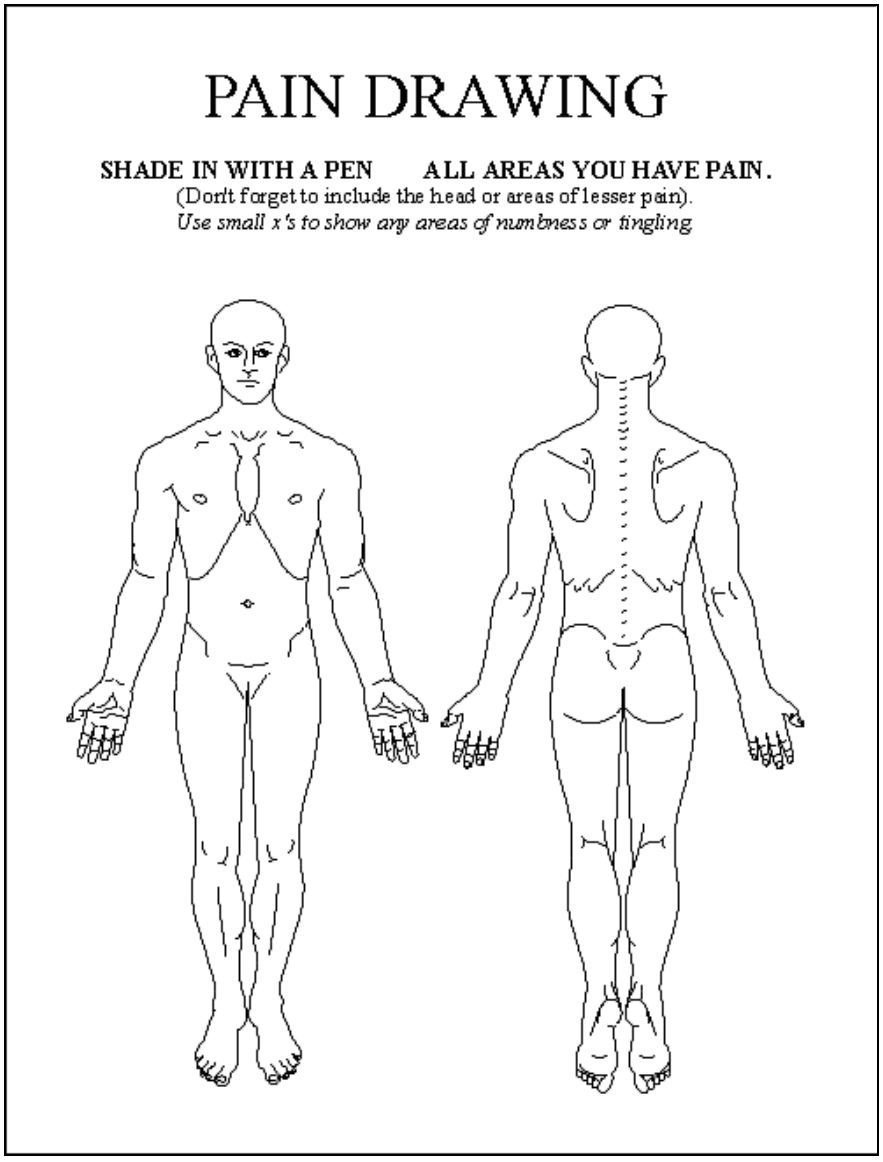
Complaint Intensity Rating Scale

How would you rate your severity of pain on a 0 – 10 scale

0	No Complaint
1 - 3	Minimal Complaint - an annoyance, causes no handicap in performance. Noticeable only when paid attention to
4 - 6	Slight Complaint - tolerable, causes some handicap in performance of the activity precipitating pain. Can still perform daily tasks
7 - 9	Moderate Complaint - tolerable, causes marked handicap in the performance of the activity precipitating pain
10	Severe, intense, incapacitating complaint - precludes performance of the activities precipitating pain. Cannot perform daily tasks

From the ratings above, on a Scale 1 – 10, please circle the number that correlates with your complaint.

Where would you rank your discomfort **RIGHT NOW**?	1	2	3	4	5	6	7	8	9	10
Where would you rank your discomfort **ON AVERAGE?**	1	2	3	4	5	6	7	8	9	10
Where would you rank your discomfort **AT IT'S WORST**	1	2	3	4	5	6	7	8	9	10



Authorization for Examination, Treatment and/or Consultation

The contact information, health history, and other information that I provided on my intake form are complete and accurate.

I authorize Dr. Brian N. Hardy and/or staff to perform the consultations, examinations and/or treatments as necessary.

I understand Dr. Brian N. Hardy has the right to accept or decline me as a patient.

I understand and agree to the information provided on these pages.

My questions, if any, were answered to my satisfaction.

_____ _____

Signature of Patient or Guardian Date

Office Policies

If I am accepted as a patient , I agree to pay for all services, including services not covered by my insurance company.

If I suspend (or terminate) my treatment without Dr. Hardy's permission, it will be understood that I have reached maximum healing for my condition.

I then agree to be fully responsible for my condition and future care

Cancellation Policy

Our Patients are very important to us!

Missed appointments are costly and take away valuable appointment time from others.

Therefore, we ask for your consideration in contacting our office at least 24 hours prior to your scheduled appointment for any changes or cancellations.

(***Missed Appointment's will be deducted as one treatment session)***

Thank you

_____ _____

Signature of Dr. Brian N. Hardy and/or Staff Date