Chiropractic Case History/Patient Information

First Name____________________ Middle Initial ___ Last Name ____________________ Nickname ______________

Address __________________________________ City _______________ State__________ Zip ______________________

E-mail address:___________________________ Home Phone # _______________ Cell Phone ______________________

SSN#_______________ Age ________ Birth Date____________ Sex: M F Marital: M S W D How many children?_____

Occupation ______________________ Employer __________________________ Office Phone__________________

Employer's Address ____________________________________ City, State, Zip _________________________________

Spouse's Name _________________ Spouse's SSN__________________________ Spouse's DOB___________________

Employer____ Office Phone ____

Employer's Address (Spouse) ________________________________City, State, Zip ____________________________

Name of Nearest Relative _________________________________ Phone_______________________________________

Address____ City, State, Zip ____

How were you referred to our office? ____

Family Medical Doctor's Name & Phone Number____

Purpose of this appointment __________________________________ Date of symptoms or accident __________________

Have you ever received chiropractic care before? ☐Yes ☐No If yes, ☐ Adjustment/Manipulation
☐ Intersegmental Traction (Roller Bed) ☐ Electrical Muscle Stimulation
Date of last physical examination_______________ What surgeries have you had? (Include dates)___________________

____

Serious illnesses, Accidents or Falls, Fractures or Dislocations (include dates)______________________________

____

Have you been treated for any health condition by a physician in the last year? ☐Yes ☐ No If yes, describe:___________

____

Daily Habits: Sleep ____(Hrs) Coffee/Tea____(Cups) Alcohol_____ Tobacco____ Exercise_____ (Days/Week)

What medications or drugs are you taking? ____

____

Have you or any member of your family ever had a nervous breakdown or mental disorder? ☐Yes ☐ No

- Place a check mark next to any of the following health concerns you have had:

☐Anemia ☐ Diabetes ☐ Epilepsy ☐ Cancer ☐ Heart Disease ☐ Alcoholism ☐ Arthritis ☐ Mental Disorder

General Symptoms

☐ Headache ☐ Sweats ☐ Fainting ☐ Dizziness ☐ Convulsions ☐ Fatigue ☐ Nervousness
☐ Weight Loss ☐ Numbness ☐ Allergy ☐ Wheezing

Respiratory & Cardio-Vascular Symptoms

☐ Chest Pain ☐ Difficult breathing ☐ Rapid beating heart ☐ Slow beating heart ☐ High blood pressure
☐ Low blood pressure ☐ Pain over heart ☐ Swelling of ankles ☐ Poor circulation ☐ Paralytic Stroke

Muscle & Joint Symptoms

☐ Stiff neck ☐ Backache ☐ Swollen joints ☐ Tremors ☐ Painful tail bone ☐ Foot Trouble
☐ Hernia ☐ Pain between shoulders ☐ Spinal curvature ☐ Faulty posture

Genitourinary Symptoms

☐ Frequent / Painful urination ☐ Blood / Pus in urine ☐ Bed wetting ☐ Un-controlled bladder
☐ Prostate trouble ☐ Kidney infection or stones

Gastrointestinal Symptoms

☐ Poor Appetite ☐ Difficult digestion ☐ Excessive hunger ☐ Belching or gas ☐ Nausea ☐ Vomiting ☐ Stomach Pain
☐ Distention of abdomen ☐ Constipation ☐ Diarrhea ☐ Colitis ☐ Hemorrhoids ☐ Liver Trouble ☐ Gall bladder trouble
☐ Jaundice

For Women Only

☐ Painful menstrual periods ☐ Excessive flow ☐ Irregular cycle ☐ Cramps or backache ☐ Previous miscarriage
☐ Vaginal discharge ☐ Lumps in breast ☐ Menopausal symptoms

NO SYMPTOMS |____| EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

1. What is your major symptom? ______________________________
2. What does this prevent you from doing or enjoying?______________________________
3. If this is a recurrence, when was the first time you noticed this problem?______________________________

   How did it originally occur?______________________________

   Has it become worse recently? ☐ Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

   If yes, when and how?______________________________
4. How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

   How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes
5. Are there any other conditions or symptoms that may be related to your major symptom? ☐ Yes ☐ No

   If yes, describe ______________________________

   Are there other unrelated health problems? ☐ Yes ☐ No If yes, describe ______________________________
6. Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing
7. Is there anything you can do to relieve the problem? ☐ Yes ☐ No If yes, describe ______________________________

   ______________________________.
8. What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting
9. Have you had any broken bones? ☐ Yes ☐ No If yes, please list and give dates ______________________________

   ____
10. List any major accidents you have had other than those that might be mentioned above: ______________________________

    ____
11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain

- Please check any and all insurance coverage that may be applicable in this case.

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident ☐ Other: __________

Name of Primary Insurance Company ______________________________

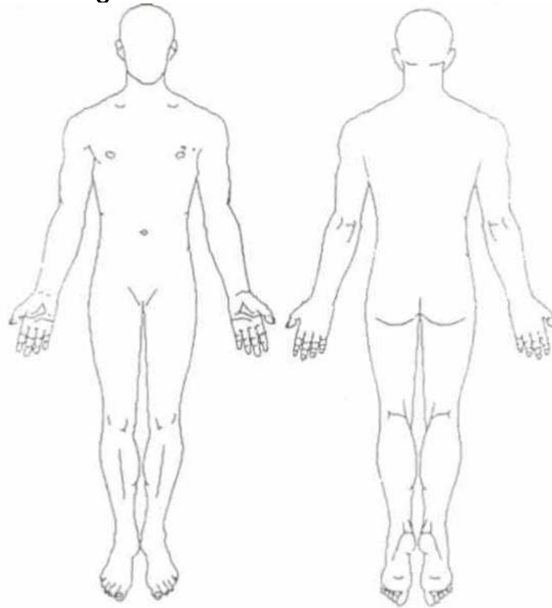
Name of Secondary Insurance Company (if any) ______________________________

Who is responsible for your bill? ☐ Self ☐ Husband/Wife ☐ Insurance ☐ Employer ☐ Other: __________

Pain Drawing

Using the letters below, mark all affected areas on your body where you feel the described sensations. Please complete the picture by drawing your face.

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing



PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone
- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone
- ☐ O.K. to leave a message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to email
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number: ___________

☐ Other: _________________________________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Privacy Policy Statement: The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's (Parent or Guardian's) Signature: ______________________________________Date________________________

Print Patient's (Parent or Guardian's) Name: ____

WELCOME TO OUR OFFICE

Procedures for New Patients

1. All new patients are requested to fill out the Chiropractic Case History/Patient Information forms.

2. Consultation with the doctor to discuss your health.

3. Preliminary screening tests to help determine whether you are a chiropractic case. If you are not accepted as a chiropractic patient, we will try to assist you in locating the type of physician or specialist which we feel your condition requires. There is no charge for these screening tests.

4. If the preliminary screening tests indicate that you are a chiropractic case, additional diagnostic examinations such as x-rays, laboratory tests, neurological/orthopedic tests, etc., may be required. If so, the necessity and cost of any such diagnostic examinations will be thoroughly explained before the examinations are performed.

5. The doctor will review with you the diagnostic examination explain their significance, and make recommendations for treatment. Family members are welcome and may attend this explanation at your request.

6. Treatments will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained. If you do not respond to treatment, or are dissatisfied with your progress, you may stop taking treatment at any time without further financial obligation, except for services previously rendered. In addition, upon request, your case records will be made available for review by the physician of your choice.

7. Affordable Financial Arrangements. If you have insurance, you'll be happy to know Medicare, Worker's Compensation, Automobile Med-Pay and most union and company health insurance policies provide chiropractic coverage. You are responsible for meeting the payment requirements of your policy regarding deductibles and co-payments, and also payment for serviced not covered by your policy. With the above exceptions, in most cases we will accept assignment and payment of benefits of the patient's insurance plans, health plans, and third party claims as payment in full for services rendered. Extended payment plans are available for patients who do not have insurance or have difficulty meeting their portion of the charges. In hardship cases, our fees are negotiable according to the patient's ability to pay. We want our services to be affordable to everyone.