

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 _____

Reason for consulting the office: Become pain free Explanation of my condition Learn how to care for my condition

Reduce symptoms Resume normal activity level

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 _____

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)

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:

General Symptoms

- Anemia Diabetes Epilepsy Cancer Heart Disease Alcoholism Arthritis Mental Disorder Depression
 Hepatitis HIV Multiple Sclerosis Neurological Problems Parkinson's Polio Headache Sweats Fainting
 Dizziness Convulsions Fatigue Nervousness Weight Loss Numbness Allergy Wheezing
 Eye/Vision Problems Hearing Problems Significant Weight Change

Respiratory & Cardio-Vascular Symptoms

- Chest Pain Difficult breathing Rapid beating heart Slow beating heart High blood pressure Asthma Pacemaker
 Low blood pressure Pain over heart Swelling of ankles Poor circulation Paralytic Stroke Minor Heart Problem

Muscle & Joint Symptoms

- Neck Pain Back Pain Swollen joints Tremors Painful tail bone Hernia Arm pain Shoulder Pain Leg Pain
 Spinal curvature Faulty posture Ankle Pain Broken Bones Elbow Pain Foot Pain Hand Pain Sprain/Strain
 Genetic Spinal Condition Hip Pain Jaw Pain Joint Stiffness Knee Pain Mid-Back Pain Spinal Cord Injury

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

Allergies

- Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Rubber Ragweed/Pollen
- Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

Surgeries

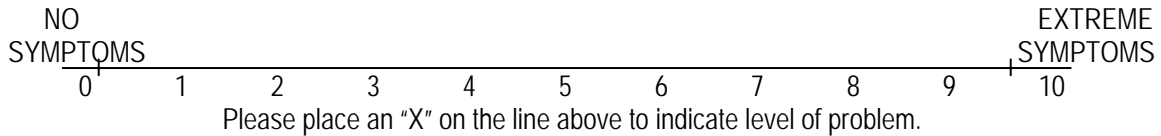
- Back Brain Elbow Foot Hip Knee Neck Neurological Shoulder Wrist Other: _____

For Women Only

- Painful menstrual periods Excessive flow Irregular cycle Cramps or backache Previous miscarriage
- Vaginal discharge Lumps in breast Menopausal symptoms Are you Pregnant?

Medications

- Anxiety Muscle Relaxers Pain Killers Insulin Birth Control Cardiovascular Allergy Seizure
- Other: _____



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 Frequent Occasional 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 Numb Tingling Aching Burning Stabbing Shooting
 Tightness Throbbing Radiating Pain Other: _____
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: _____

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

- Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other: _____

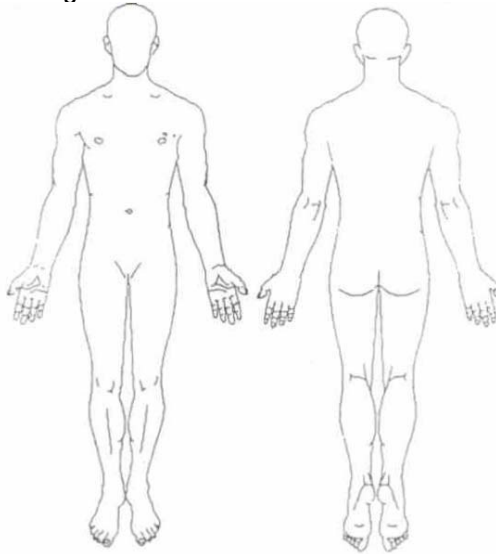
Name of Primary Insurance Company _____ Secondary (if any) _____

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):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone
<input type="checkbox"/> O.K. to leave a message with detailed information
<input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/> Work Telephone
<input type="checkbox"/> O.K. to leave a message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to email
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number: _____

<input type="checkbox"/> 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.