

# 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? \_\_\_\_\_  
Race: \_\_\_\_\_ Ethnicity: Hispanic or Latino Neither Preferred Language: \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Office Phone \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's SSN \_\_\_\_\_ Spouse's DOB \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Office Phone \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_  
Employer's 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 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: \_\_\_\_\_  
\_\_\_\_\_  
Medications (how much and how often) \_\_\_\_\_  
\_\_\_\_\_  
Daily Habits: Sleep \_\_\_\_\_(Hrs) Coffee/Tea \_\_\_\_\_(Cups) Alcohol \_\_\_\_\_(Drinks/Day) Tobacco \_\_\_\_\_(Day) 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

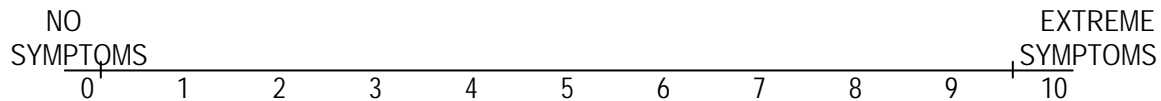
Back  Brain  Elbow  Foot  Hip  Knee  Neck  Neurological  Shoulder  Wrist  Other: \_\_\_\_\_

### 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?

### Smoking Status

Every Day  Some Day  Former (Start Date \_\_\_\_\_ End Date \_\_\_\_\_)  Never  Trying to Quit (Method) \_\_\_\_\_



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  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: \_\_\_\_\_

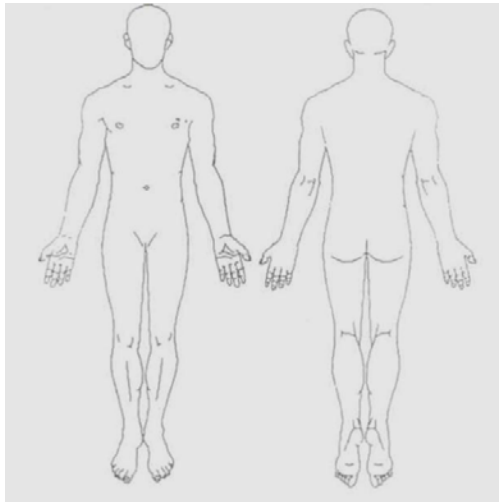
Name of Primary Insurance Company \_\_\_\_\_ Secondary (if any) \_\_\_\_\_

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<br><input type="checkbox"/> O.K. to leave a message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone<br><input type="checkbox"/> O.K. to leave a message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to email<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number: _____<br><br><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 a failure to pay will result in a minimum collection fee of \$25.00 and contact from a third party collection company.

**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.

Would you like access to an electronic copy of your health information (including diagnostic test results, problem list, medication lists, and medication allergies)?  Yes  No

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 services 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. A failure to pay will result in a minimum collection fee of \$25.00 and contact from a third party collection company. We want our services to be affordable to everyone.