CONFIDENTIAL PATIENT CASE HISTORY

WELCOME TO OUR OFFICE!
Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

PERSONAL INFORMATION

Name:_____ Date:_____

Date of Birth:_____/_____/_____ Age:_____ Sex: ❑ Male ❑ Female Marital Status: S / M / D / W

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

Social Security #:_____-_____-_____ Home Phone:(_____) _____-_____

Cell Phone:(_____)_____-_____ E-mail:_____

Occupation:_____ Employer:_____

Employer Address:_____ Work Phone:(_____)_____-_____

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

Employer Address:_____ Work Phone:(_____)_____-_____

Social Security #:_____-_____-_____ How Many Children (Ages)?:_____

Emergency Contact:_____ Phone:(_____) _____-_____

Who Referred You To Us?:_____

How Else Did You Hear About Us?:_____

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom?:_____

How long have you had this condition?:_____

Have you had this or similar conditions in the past?:_____

What do you think caused this condition?:_____

What position(s), if any, make it feel worse?:_____

What position(s), if any, make it feel better?:_____

Over time, is this condition: ❑ Improving ❑ Unchanged ❑ Getting Worse?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine Other:_____

Have you sought advice or treatment from other doctors or therapists for ***this*** condition? ❑ Yes ❑ No

If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

Name	Date of visit	Diagnosis

Describe any treatment you have had for ***this*** condition (include medication dosage and frequency)?:_____

_____

_____

Family Medical Doctor:_____ Address:_____ Date of Last Physical:_____

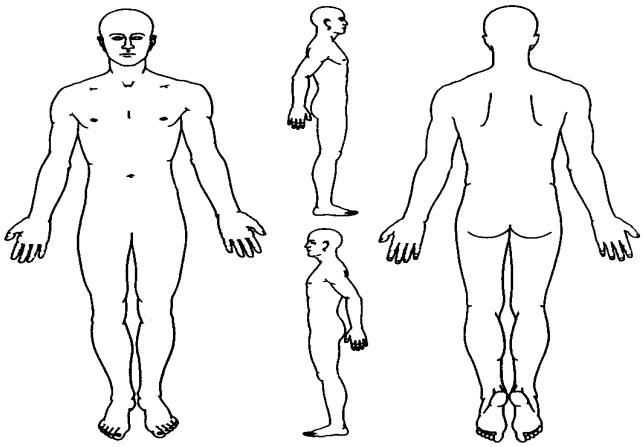
May we communicate our findings on your current health condition to the above provider(s)? ❑ Yes ❑ No

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.



Primary Complaint:

1) _____ 1 2 3 4 5 6 7 8 9 10

Additional Complaints:

2) _____ 1 2 3 4 5 6 7 8 9 10
3) _____ 1 2 3 4 5 6 7 8 9 10
4) _____ 1 2 3 4 5 6 7 8 9 10
5) _____ 1 2 3 4 5 6 7 8 9 10

PREVIOUS CONDITIONS

Days Lost From Work:_____ Date of Last Physical Examination: _____

Have you sought care for another health condition in the past year? ❑ Yes ❑ No Past 2 years? ❑ Yes ❑ No

If yes, what condition other than your primary complaint?:_____

Was treatment administered? ❑ Yes ❑ No Describe: _____

_____

Do you take medications? ❑ Yes ❑ No List Dosage, Frequency and Reason:_____

_____

_____

Any prior hospitalizations or surgery? ❑ Yes ❑ No Describe with dates:_____

_____

Have you been in an auto accident or had any other personal injury? ❑ Yes ❑ No Describe:_____

_____

CHIROPRACTIC HISTORY

Previous Chiropractic care? ❑ Yes ❑ No If yes, Doctor's name:_____

Date of last chiropractic visit: _____/_____/_____ Date of last chiropractic X-rays:_____/_____/_____

Reason for care:_____ How long were you under care?: _____

Were you satisfied with the previous chiropractic care you received? ❑ Yes ❑ No

Are other family members under chiropractic care? ❑ Yes ❑ No Who?: _____

Are you open to looking at new ideas in health and wellness? ❑ Yes ❑ No

SOCIAL HISTORY

Height:_____ft. _____in. Current Weight:_____ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Physical Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per week:_____ Type:_____

Smoking: ❑ Never ❑ Currently ❑ Previously Packs/day:_____, Pack/week:_____ How long?:_____

Alcohol: Beer/week:_____, Liquor/week:_____, Wine/week:_____ How long?:_____

Caffeine: Cups/day:_____ How long?:_____ Aspirin: No./day:_____ How long?:_____

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

REVIEW OF SYSTEMS (NOW=within the past 1 year; PAST=over one year ago)

GENERAL	Now	Past
Weakness	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
SKIN		
Color Changes	❑	❑
Nail Changes	❑	❑
Hair Changes	❑	❑
Moles	❑	❑
Rashes	❑	❑
Sores	❑	❑
Weakness	❑	❑
HEAD & EYES		
Headaches	❑	❑
Injuries	❑	❑
Bumps	❑	❑
Last Eye Exam	❑	❑
Glasses	❑	❑
Contacts	❑	❑
Cataracts	❑	❑
EARS		
Hard of Hearing	❑	❑
Deafness	❑	❑
Ringing	❑	❑
Discharge	❑	❑
Earache	❑	❑
Itching	❑	❑
Dizziness	❑	❑
Room Spins	❑	❑
NOSE		
Decreased Smell	❑	❑
Bleeding	❑	❑
Pain	❑	❑
Discharge	❑	❑
Obstruction	❑	❑
Post Nasal Drip	❑	❑
Deviated Septum	❑	❑
Runny Nose	❑	❑
Sinus Congestion	❑	❑
MOUTH		
Bleeding Gums	❑	❑
Sores	❑	❑
Dental Problems	❑	❑
Bad Breath	❑	❑
Loss of Taste	❑	❑
Dry Mouth	❑	❑
Ulcers	❑	❑
Blisters	❑	❑
THROAT		
Soreness	❑	❑
Bad Tonsils	❑	❑
Hoarseness	❑	❑
Pain	❑	❑
Trouble Swallowing	❑	❑
Recurrent Infections	❑	❑
NECK		
Neck Enlargement	❑	❑
Stiff Neck	❑	❑
Soreness	❑	❑
Lumps	❑	❑
Masses	❑	❑

BREASTS	Now	Past
Discharge	❑	❑
Lumps	❑	❑
Pain	❑	❑
Bleeding	❑	❑
Nipple Changes	❑	❑
Skin Changes	❑	❑
Bloated	❑	❑
RESPIRATORY		
Cough	❑	❑
Phlegm	❑	❑
Blood	❑	❑
Short of Breath	❑	❑
Wheezing	❑	❑
Pain	❑	❑
Congestion	❑	❑
Inhalant exposure	❑	❑
CARDIOVASCULAR		
Murmur	❑	❑
Palpitations	❑	❑
Rapid Heartbeat	❑	❑
Swollen Extremities	❑	❑
Cold Extremities	❑	❑
Chest Pain,Pressure	❑	❑
Varicose Veins	❑	❑
Blood Clots	❑	❑
Blue Extremities	❑	❑
BLOOD		
Anemia	❑	❑
Low Blood Iron	❑	❑
Easy Bruising	❑	❑
Easy Bleeding	❑	❑
Swollen Nodes	❑	❑
Painful Nodes	❑	❑
Sugar in Blood	❑	❑
Red Spots	❑	❑
GASTROINTESTINAL		
Abdominal Pain	❑	❑
Nausea	❑	❑
Bloated	❑	❑
Belching	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Irreg. Bowel Habits	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas	❑	❑
Hemorrhoids	❑	❑
Poor Appetite	❑	❑
Food Intolerance	❑	❑
Bloody Stools	❑	❑
Black Stools	❑	❑
GENITOURINARY		
Urgency	❑	❑
Incontinence	❑	❑
Straining	❑	❑
Back Pain	❑	❑
Frequent Voiding	❑	❑
Stones	❑	❑
Burning	❑	❑
Bed Wetting	❑	❑
Small Stream	❑	❑
Discharge	❑	❑
Impotence	❑	❑

GENITOURINARY	Now	Past
Dribbling	❑	❑
Cloudy Urine	❑	❑
Spotting	❑	❑
Menstrual Cramps	❑	❑
Painful Menses	❑	❑
Itching	❑	❑
Painful Intercourse	❑	❑
Irregular Periods	❑	❑
Hot Flashes	❑	❑
NEUROLOGICAL		
Seizures	❑	❑
Vertigo	❑	❑
Dizziness	❑	❑
Hand Trembling	❑	❑
Loss of Sensation	❑	❑
Incoordination	❑	❑
Loss of Facial	❑	❑
Weak Grip	❑	❑
Paralysis	❑	❑
Difficulty Speech	❑	❑
Tingling	❑	❑
Loss of Memory	❑	❑
Numbness	❑	❑
ENDOCRINE		
Weight Loss	❑	❑
Weight Gain	❑	❑
Extremely Thin	❑	❑
Heat Intolerance	❑	❑
Cold Intolerance	❑	❑
Hair Changes	❑	❑
Breast Changes	❑	❑
IMMUNIZATION/VACCINATION		
DPT	❑	❑
Mumps	❑	❑
Smallpox	❑	❑
Typhoid	❑	❑
Tetanus	❑	❑
Measles	❑	❑
Pneumococcal	❑	❑
Influenza	❑	❑
Polio	❑	❑
MMR	❑	❑
PSYCHIATRIC		
Hyperventilation	❑	❑
Insecurity	❑	❑
Depression	❑	❑
Troubles Sleep	❑	❑
Irritable	❑	❑
Hallucinations	❑	❑
Loss of Memory	❑	❑
Alcoholism	❑	❑
Drug Addiction	❑	❑
Drug Dependent	❑	❑
Suicidal Thoughts	❑	❑
Extreme Worry	❑	❑
Sexual Problems	❑	❑
MUSCULOSKELETAL		
Muscle Pain	❑	❑
Muscle Weakness	❑	❑
Muscle Cramps	❑	❑
Muscle Stiffness	❑	❑
Joint Stiffness	❑	❑
Joint Pain	❑	❑

PAST MEDICAL HISTORY

Check only the ones you have had in the past.

Hay Fever	❑
Mumps	❑
Rheumatic Fever	❑
Allergies	❑
Angina	❑
Cancer	❑
Tumor	❑
Blood Disease	❑
Leukemia	❑
Heart Trouble	❑
Varicose Veins	❑
Phlebitis	❑
Hypertension	❑
Stroke	❑
Ulcers	❑
Jaundice	❑
Skin Trouble	❑
Gallstones	❑
Liver Trouble	❑
Hepatitis	❑
Parasites	❑
Epilepsy	❑
Paralysis	❑
Polio	❑
Mental Illness	❑
Alcoholism	❑
Depression	❑
Nervous Breakdown	❑
Migraine	❑
Gout	❑
Hemorrhoids	❑
Prostate Problems	❑
Sexual Problems	❑
Gonorrhea	❑
Syphilis	❑
Diabetes	❑
Bladder Trouble	❑
Kidney Stones	❑
Kidney Infections	❑
Dysentery	❑

ALLERGIES

List known allergies below

_____
_____
_____
_____
_____
_____
_____

If Female,
Are You Pregnant?

❑ **Yes**
❑ **No**

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

FAMILY HISTORY - List any of the diseases listed previously which run in your family

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses (if any)
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandfather (Mat):	_____	_____	_____	_____	_____
Grandmother (Mat):	_____	_____	_____	_____	_____
Grandfather (Pat):	_____	_____	_____	_____	_____
Grandmother (Pat):	_____	_____	_____	_____	_____

Spouses Health Status: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Children's ages and health status:_____

_____

INSURANCE INFORMATION

Who is responsible for this account?: _____

Relationship to Patient?: _____ Social Security No: _____-_____-_____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

Is patient covered by additional or secondary insurance? ❑ Yes ❑ No

Subscriber's Name: _____

Relationship to Patient?: _____ Birth Date: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email and phone in regards to treatment as well as promotional activities. This clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

AGREEMENTS and AUTHORIZATION

Consent To Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by this office. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____ initial

Payment Guarantee

In consideration of the services provided by this office, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to this office, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to this office. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

_____ initial

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance, massage and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ initial

Patient Right To Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ initial

Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by this office for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

AUTHORIZATION and HIPAA PRIVACY NOTICE

Consent To Release Information

Here at this office, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment , plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ initial

HIPAA Privacy Notice Patient Acknowledgment

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby state that by signing this Consent I acknowledge and agree as follows:

1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
2) The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
5) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ initial

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

PRINTED Name of Patient, Parent or Guardian: _____

SIGNATURE of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)