Chiropractic Case History/Patient Information

Date:_____ Patient #_____ Doctor:_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? x Yes x No
If yes, describe: _____
Please list any other health problems you have no matter how insignificant they may be:
_____
_____
SOCIAL HISTORY:
Do you drink alcoholic beverages? _____ If so, how much per week?_____
Do you use any tobacco products? _____ Do you smoke? _____ if so, packs per day: _____
Do you take vitamin supplements? _____ if so, please list: _____
Do you consume caffeine? _____ If so, how much per day: _____
Do you exercise? _____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
Standing: _____ Sitting: _____ bending: _____ Working at a computer: _____
FAMILY HISTORY:
Parents:
Father: living _____ deceased _____ Current age if still living: _____ Cause of death and age at death if deceased: _____ (check one)
Mother: living _____ deceased _____ Current age if still living: _____ Cause of death and age at death if deceased: _____ (check one)
Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? If so, please list:
_____
FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis _____	Cancer _____	Mental Illness _____
Diabetic _____	Asthma _____	Heart Disease _____
Stroke _____	Kidney Disease _____	Lung Disease _____
Arthritic _____	Liver Disease _____	

Other _____
Please check any and all insurance coverage that may be applicable in this case:
x Major Medical x Worker's Compensation x Medicade x Medicare x Auto Accident
x Medical Savings Account & Flex Plans x Other
Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

AUTHORIZATROIN 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.

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 Signature: _____ Date: _____
Guardian's Signature Authorizing Care; _____ Date: _____

SUMMARY

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 _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS _____ EXTREME SYMPTOMS

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

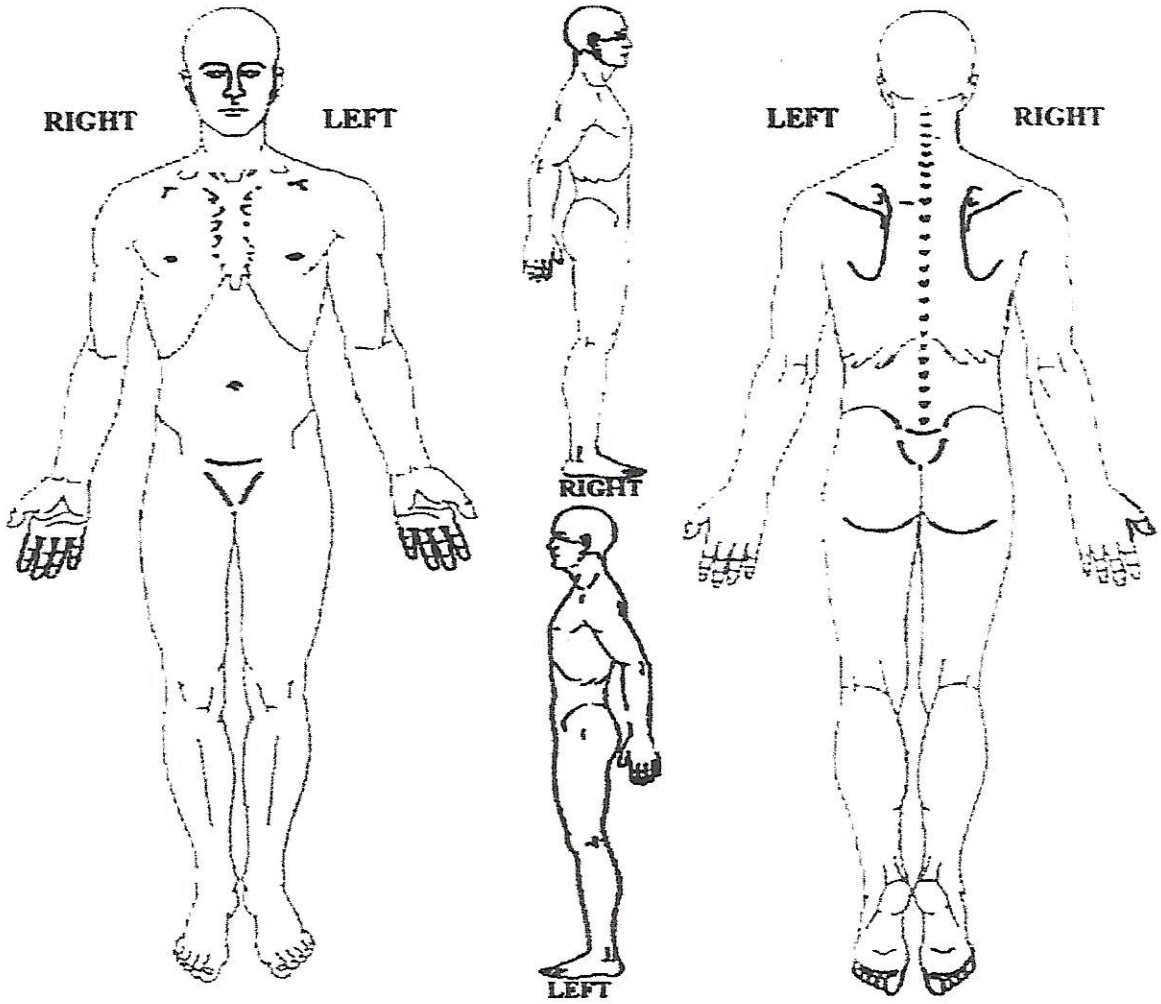
Doctor's Signature _____ Date _____

Pain Scale

Patient Name: _____ Date: _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



How severe is your pain today? Place an "X" on the line below to indicate how bad you feel <u>your pain is today</u>.

No Pain |_____| Very Severe Pain

<u>Additional Comments</u>

_____

_____

_____

_____

Low Back Pain and Disability Questionnaire

Patient name: ---------- File # -------- Date: ---------

Please read instructions: when your back hurts, you may find it difficult to do some of the things you normally do. Mark only the sentences that describe you today.

I stay at home most of the time because of my back

I change position frequently to try to get my back comfortable

I walk more slowly than usual because of my back

Because of my back, I am not doing any jobs that I usually do around the house

Because of my back, I use a handrail to get upstairs

Because of my back, I lie down to rest more often

Because of my back, I have to hold on to something to get out of an easy chair

Because of my back, I try to get other people to do things for me

I get dressed more slowly than usual because of my back.

I only stand up for short periods of time because of my back

Because of my back, I try not to bend or kneel down

I find it difficult to get out of a chair because of my back

My back is painful almost all of the time

I find it difficult to turn over in bed because of my back

My appetite is not very good because of my back

I have trouble putting on my sock (or stockings) because of the pain in my back

I can only walk short distances because of my back pain

I sleep less well because of my back

Because of my back pain, I get dressed with the help of someone else

I sit down for most of the day because of my back

I avoid heavy jobs around the house because of my back

Because of back pain, I am more irritable and bad tempered with people than usual

Because of my back, I go upstairs more slowly than usual

I stay in bed most of the time because of my back

For Office use only:

Score_____

Improvement_____ %

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both parties to be working towards the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be utilized while receiving your chiropractic care as this will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition(s) and the recommendations of the care to be provided so that you make the decision whether or not to undergo chiropractic adjustment(s) after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structures and the health of the nervous system. As Doctors of Chiropractic, we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation and/or vertebral subluxation complex. A vertebral subluxation complex or VSC, is a dysfunctional biomechanical spinal segment which is fixated. These dysfunction(s) alter neurological function, which in turn, causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction, visceral disorders, or may be entirely asymptomatic (symptom free).

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position to allow for improved function and communication within the nervous system.

Our objective as Doctors of Chiropractic is to solely identify and reduce the extent of any vertebral subluxation(s). If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name Signature Date

Patient Health Information Consent

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use his/her Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Name of Patient Date