Chiropractic Case History/Patient Information

Date:_____ Patient #:_____ Doctor:_____

Name:_____ SSN:_____ Home #:_____

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

Email Address:_____ Cell Phone:_____

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

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

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? YES NO

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? YES NO If yes, when and describe:_____

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

PAST MEDICAL HISTORY

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

___ Broken 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 illness, 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? YES NO If yes, describe:_____

_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? YES NO If yes, describe:_____

_____

Do you have any allergies of any kind YES 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? YES NO If so, how much per week? _____

Do you use any tobacco products? YES NO Do you smoke? YES NO If so, packs per day:_____

Do you take vitamin supplements? YES NO If so, please list:_____

Do you consume caffeine? YES NO If so, how much per day:_____

Do you exercise? YES NO If yes, what is the frequency and type of exercise?_____

What percentage of time during the day (at home or at your job away from home) do you spend: Lifting_____

Sitting_____ Bending_____ working at the computer_____

FAMILY HISTORY (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Parents:

Father: Living____ Deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____

Mother: Living____ Deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____

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

Tuberculosis___	Cancer___	Mental Illness____
Diabetes____	Asthma___	Heart Disease____
Stroke___	Kidney Disease___	Lung Disease____
Arthritis____	Liver Disease___	Other_____

The patient understands and agrees to all this chiropractic office to use the 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 don't want to receive your medical records please inform our office.

It is your responsibility to provide full payment for treatment received by our office. By signing you are assuming financial responsibility for all charges.

Patient's Signature:_____ **Date**:_____

Guardian's Signature Authorizing Care:_____ Date:_____

SUPER HELPFUL INFORMATION

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. 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. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____

    _____
12. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____
13. Remarks: _____

    _____

    _____

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

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

Doctor's Signature _____ Date _____

Payment Policy

1. Chiropractic services provided in this office are payable the day services are rendered unless other agreements have been made prior to seeing the doctor.

2. Patients are personally responsible for charges. If the staff is unable to verify insurance benefits prior to the end of your first visit, payment is due in full.

3. There will be a $35.00 charge for returned checks due to nonsufficient funds (NSF). After two NSFs, checks can no longer be accepted as a method of payment.

4. Our offices file for MEDICARE ONLY, provided that industry standard claims process is used. Out of network claims requiring paperwork above and beyond the industry standard process is the responsibility of the patient. Secondary insurance claims will be processed by our office, provided that cross-over claims processes are linked between the primary and secondary insurance companies.

5. Assignment of insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office. Benefits quoted by insurance companies are not a guarantee of payment. Benefits are determined at the time of claims processing.

6. Any balance remaining after 60 days with no action on the account will be charged 18% per annual service charge.

7. The following services/products are standardly denied by insurance companies and our office does not bill these services and products to insurance companies. The initial exam, supplements, pillows, custom orthotics, nutritional consultations, and nutritional supplements.

8. We will make every attempt to verify your insurance coverage prior to rendering service. However, insurance companies may disallow certain procedures without our knowledge. You agree to pay for any services received, regardless of insurance coverage.

9. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.

10. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. I also understand that if I suspend or terminate my schedule of care as determined by the treating doctor, any fees for professional services will be immediately due and payable.

I HAVE READ, UNDERSTAND, AND AGREE WITH THE PAYMENT POLICY:

PATIENT SIGNATURE:_____ DATE: _____

WITNESS SIGNATURE: _____DATE: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method utilized to achieve this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of pain, disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom by correcting vertebral subluxations. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(patient signature) (date)

_____
(witness)

Patient Health Information Consent Form

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 their 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.

Patient Signature Date