Chiropractic Case History/Patient Information

Date _____

Name _____ Social Security #_____Home Phone _____

Address _____City _____ State _____ Zip _____

E-mail Address _____ Fax # _____ Cell Phone _____

Best place to leave message: ☐ Home ☐ Work ☐ Cell ☐ Other _____

Age _____ Birth Date _____ Race _____ Marital: M S W D How many children?_____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Spouse's Birth Date_____

Name of Nearest Relative _____ Address _____Phone _____

How were you referred to our office? _____

Family Medical Doctor _____ Doctor's Address_____

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

Purpose of this appointment _____ **Is this due to: Auto___ Work____ Other___**

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition? ☐Yes ☐ No

If yes, when and describe: _____

Days lost from work _____ Date of last physical examination _____

What surgeries have you had? (Include Dates) _____

_____

Serious illnesses (Include Dates) _____

_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

_____

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? _____

_____

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 _____

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

Yes _____ No _____ Uncertain _____

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 payors and to secure the payment of benefits. I authorize the release of my medical records and information to other healthcare providers, which this office may utilize or be in contact with such as PCP. 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.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Doctor's Signature:_____ Date: _____

Name:_____ Date:_____

HEALTH HISTORY- Please circle Yes or No. Please do not leave any questions blank.

Y N Heart Attack/ Stroke	Y N Heart Surgery/ Pacemaker	Y N Artificial Valves
Y N Broken or Fractured Bones	Y N Osteoarthritis	Y N Eating Disorder
Y N Circulatory Problems	Y N Epilepsy	Y N Diabetes
Y N Rheumatoid Arthritis	Y N Seizures/Convulsions	Y N HIV Positive / AIDS
Y N Cancer	Y N Alcohol/ Drug Abuse	Y N Gall Bladder Problems
Y N Excessive Bleeding	Y N Depression	Y N Chemotherapy/Radiation
Y N High/Low Blood Pressure	Y N Ulcers/Colitis	Y N Severe Headaches

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:
Lifting_____ Sitting_____ Bending_____ Standing_____ Working at a computer_____Sleeping_____

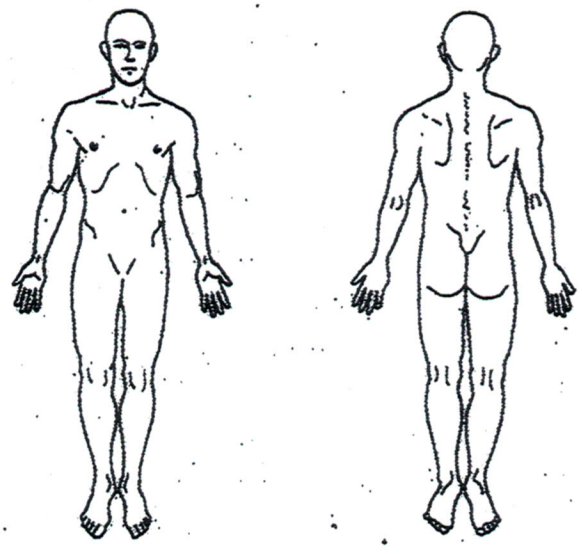
FAMILY HISTORY: DISEASES (indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis____	Cancer____	Mental Illness____	Diabetes ____	Asthma____
Heart Disease ____	Stroke ____	Kidney Disease____	Lung Disease____	Arthritis_____
Liver Disease ____	Other _____			

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~ ~



Doctor's Signature:_____ Date:_____

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.

Name of Patient Signature of Patient Date

Doctor's Signature: _____ Date: _____

Informed Consent

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, **the serious risks associated with the chiropractic adjustment are extremely rare.**

Following are the known risks: Temporary soreness or increased symptoms or pain It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. Disc herniation or prolapse Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke. Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat. Bruising Instrument assisted soft tissue manipulation may result in temporary soreness or bruising. I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

• PATIENT PLEASE REVIEW • PRINT & SIGN NAME • I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____

DATE OF BIRTH_____

_____ _____ (PATIENT | GUARDIAN SIGNATURE) (DATE)

_____, D.C. _____