Confidential Patient Case History

Date ____________________

Name ____ Home Phone________________ Cell Phone________________

Address ____ City ______________ State______ Zip __________

Age ____ Birth Date __________ Sex M F Marital Status M S W D Number of Children _____ SS#________________

Employer ________________________ Occupation _____________________ e-mail __________________________

Work Address ____ Work Phone ___________________

Name of Spouse ____Spouse's Work Phone _______________________

In Case of Emergency, please notify ________________________________ Phone _____________________________

How did you hear about our office? Friend ______________________ □ Phonebook □ Employer □ Internet □ Other

Please list complaints and date the condition started, starting with your major complaint.

Complaints	Date Started
1. ______________________________	1. ____________________
2. ______________________________	2. ____________________
3. ______________________________	3. ____________________
4. ______________________________	4. ____________________

Is your condition getting worse? □ Yes □ No Is it Constant? □ Yes □ No Comes and Goes? □ Yes □ No
Have you seen other doctors for this condition? □ Yes □ No

Please list other doctors seen and approximate date seen (including primary care physician):

Doctor	Approximate Date Seen
1. ______________________________	1. ____________________
2. ______________________________	2. ____________________
3. ______________________________	3. ____________________

Have you experienced any serious accidents or falls within the □ Past year? □ 5 years? □ Over 5 years □ Never

If you have experienced an accident, what type was it? □ Auto □ Work □ Home □ Leisure □ Sports □ Other _______

Briefly Explain: ____

Are you presently taking any medication? □ Yes □ No Please List ____

List Surgical procedures you have had and an approximate date.

Procedure	Date
1. ______________________________	1. ____________________
2. ______________________________	2. ____________________
3. ______________________________	3. ____________________

Has any blood relative ever had:

	Who		Who
Cancer	______________	Stroke	______________
Diabetes	______________	Arteriosclerosis	______________
Heart Trouble	______________	Arthritis	______________
High Blood Pressure	______________	Spinal Curvature	______________

Check the following that you have had:

□ Alcoholism	□ Chorea	□ Gout	□ Multiple Sclerosis	□ Stroke
□ Anemia	□ Cold Sores	□ Heart Disease	□ Mumps	□ Tuberculosis
□ Appendicitis	□ Diabetes	□ Influenza	□ Pleurisy	□ Typhoid Fever
□ Arteriosclerosis	□ Diptheria	□ Lumbago	□ Pneumonia	□ Ulcers
□ Arthritis	□ Eczema	□ Measles	□ Polio	□ Whooping Cough
□ Asthma	□ Emphysema	□ Migraines	□ Rheumatic Fever	
□ Cancer	□ Epilepsy	□ Miscarriage	□ Scarlet Fever	

Check the following symptoms you have had within the past year:

General
- □ Allergy
- □ Chills
- □ Convulsions
- □ Dizziness
- □ Fainting
- □ Fatigue
- □ Fever
- □ Headache
- □ Loss of Sleep
- □ Loss of weight
- □ Depression
- □ Neuralgia
- □ Sweats
- □ Tremors

Cardiovascular
- □ Chest pain
- □ Angina
- □ ↑ blood pressure
- □ Low blood pressure
- □ Poor circulation
- □ Rapid Heart beat
- □ Slow heart beat
- □ Ankle swelling

Muscle & Joint
- □ Arthritis
- □ Bursitis
- □ Foot trouble
- □ Hernia
- □ Low back pain
- □ Lumbago
- □ Neck Pain
- □ Shoulder Pain

Pain or numbness in:
- □ Shoulders
- □ Arms
- □ Elbows
- □ Hands
- □ Hips
- □ Legs
- □ Knees
- □ Feet
- □ Tailbone

- □ Poor Posture
- □ Sciatica
- □ Spinal Curvature
- □ Swollen joints

Eyes, Ears, & Nose
- □ Asthma
- □ Colds
- □ Crossed Eyes
- □ Deafness
- □ Dental Decay
- □ Ear Ache
- □ Ear Discharge
- □ Ear Noises
- □ Enlarged glands
- □ Enlarged thyroid
- □ Eye pain
- □ Failing vision
- □ Far sightedness
- □ Gum trouble
- □ Hay fever
- □ Hoarseness
- □ Nasal obstruction
- □ Near sightedness
- □ Nosebleeds
- □ Sinus Infection
- □ Sore throat
- □ Tonsillitis

Respiratory
- □ Chest pain
- □ Chronic cough
- □ Difficulty breathing
- □ Spitting up blood
- □ Spitting up phlegm
- □ Wheezing

Gastro-intestinal
- □ Belching or gas
- □ Crohn's disease
- □ Colitis
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficult Digestion
- □ Gall Bladder trouble
- □ Hemorrhoids
- □ Jaundice
- □ Liver trouble
- □ Nausea
- □ Stomach pain
- □ Poor appetite
- □ Vomiting
- □ Rectal pain

Skin
- □ Bruise easily
- □ Dryness
- □ Hives or allergy
- □ Itching
- □ Rashes
- □ Varicose Veins

Genito-urinary
- □ Bed wetting
- □ Blood in urine
- □ Frequent urination
- □ Bladder control
- □ Kidney infection
- □ Painful urination
- □ Prostate trouble

Women Only
- □ Cramps
- □ Excessive flow
- □ Hot Flashes
- □ Irregular cycles
- □ Menopause
- □ Painful Flow
- □ Vaginal Discharge

	Yes	No
Have you ever been knocked unconscious?	◻	◻
Do you use a cane or other support?	◻	◻
Have you been treated for a spine or nerve disorder?	◻	◻
Have you ever had a fractured bone?	◻	◻
Have you been hospitalized for anything other than surgery?	◻	◻
Do you smoke?	◻	◻
Do you now take vitamins or minerals?	◻	◻

Habits:

	Heavy	Moderate	Light	None
Alcohol	◻	◻	◻	◻
Coffee	◻	◻	◻	◻
Tobacco	◻	◻	◻	◻
Drugs	◻	◻	◻	◻
Exercise	◻	◻	◻	◻
Sleep	◻	◻	◻	◻
Appetite	◻	◻	◻	◻

Date of Last:

	< 6 months	6-18 months	>18 months	Never
Spinal Examination	◻	◻	◻	◻
Physical Examination	◻	◻	◻	◻
Blood test	◻	◻	◻	◻
Chest x-ray	◻	◻	◻	◻
Spinal x-ray	◻	◻	◻	◻
Dental x-ray	◻	◻	◻	◻
Urine test	◻	◻	◻	◻

Are you pregnant? ◻ Yes ◻ No
How many weeks? _______________

Please check the type of care you desire so that we may be guided by your wishes when possible:

◻ I prefer the doctor to select the type of care he feels is best for me ◻ Maximum improvement ◻ Temporary relief

Are you insured? ◻ Yes ◻ No Company ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature ____ Date ______________________________

Guardian's Signature ____ Date ______________________________

INFORMED CONSENT

Chiropractic is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty, we cannot promise a cure, but we will give you the best care possible and discuss any questions or concerns with you.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat, ultrasound or electrical muscle stimulation may irritate the skin. There have been rare cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology. The most recent studies (Journal of the CAA, Vol. 37, No 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature____
Date_____________

Parent/Legal Guardian Signature____________________________
Date_____________

NOTICE OF PRIVACY PRACTICES

- We will use your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations.
- We have updated our electronic billing software to be HIPAA compliant.
- It is possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews.
- Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment.
- We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence.
- We may be required to disclose to Federal officials or military authorities, health information necessary to complete an investigation related to public health or national security.
- We will not disclose your health information other than with your written authorization.

YOU HAVE THE RIGHT :

- To request restriction on certain uses and disclosures for your health information.
- To request that we communicate with you in a certain way.
- To read, review and copy your health information, including your complete chart, x-rays and billing records.
- To ask us to update or modify your records if you believe your health information records are incorrect or incomplete.
- To ask us for a description of how and where your health information was used by our office for any reason other than treatment, payment or health operations.
- To obtain copies of this Notice of Privacy Practices.
- To express complaints to us or to the Secretary of Health & Human Services if you believe your privacy rights have been compromised.

Patient Acknowledgment

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much you acknowledging your receipt of our policy by signing, dating and returning this notice.

____ ______________________________

Patient Signature Date