CONFIDENTIAL CASE HISTORY RECORD

Please fill out the following form in as much detail as possible. Please print neatly.

Date: _____

Full Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Work#:** _____

Fax #: _____ **Email Address:** _____

Date of Birth: _____ **Age:** _____ **Gender (Please Circle): M F**

Weight: _____ **Height:** _____

SS #: _____ **Presently Serving in Military? Y N**

Marital Status (Please Circle): Single Married Widowed Divorced Separated

Name of Spouse: _____ **BD:** _____ **SS#:** _____ **# of Children** _____

Employer: _____ **Address:** _____

Referred By: _____
Is any other member of your family being treated in this office? _____

Primary Care Physician: _____ **Telephone #:** _____

Have you ever had chiropractic before? Y N For what problem? _____

Were the results satisfactory? Y N N/A

Major complaints and symptoms – please be as specific as you can: _____
_____

How do you believe your problem (pain) began? _____

What positions or activities aggravate your condition? _____

Have you been treated by a medical physician for this ailment? Y N Where? _____

Type of Treatment? _____ Diagnosis of Physician: _____

Length of time under care: _____Results: _____

Current Medications: _____

Allergies: _____

Have you ever been in any accidents, (auto, fall down, etc.) at any age? _____

When?_____

Have you ever broken any bones? _____Dislocations: _____

Past Operations: _____ Year _____

_____ Year _____

_____ Year _____

Recent Medical Tests (i.e. Blood tests, X-ray examinations): _____

_____

Any other Health Problems not already listed: _____

_____

Do you faint easily? Y N Vitamins Taken: _____

Habits (Please Check): Cigarettes _____ Quantity_____

Coffee _____ Quantity_____

Tea_____ Quantity_____

Alcohol _____ Quantity_____

Recreational Drug Use _____

Have you gained/lost weight in the past year? _____

How often/what types of exercise do you do weekly? _____

Additional Information you may wish to discuss: _____

_____

Date of onset of last menstrual period: _____

Is there a chance that you may be pregnant? Y N N/A

Have you experienced any of the following symptoms presently or in the past? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now/Past		Now/Past
Headaches	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Diarrhea	_____
Nervousness	_____	Cold Feet	_____
Tension	_____	Cold Hands	_____
Irritability	_____	Arthritis	_____
Chest Pains	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Stomach Upset	_____
Pins & Needles in Arms	_____	Constipation	_____
Pins & Needles in Legs	_____	Cold Sweats	_____
Numbness in Fingers	_____	Fever	_____
Numbness in Toes	_____	Sinus Problems	_____
High Blood Pressure	_____	Diabetes	_____
Difficulty Urinating	_____	Hemorrhoids	_____
Allergies	_____	Leg Cramps	_____
Weakness in Arms	_____	Colitis	_____
Weakness in Legs	_____	Gall Bladder	_____
Shortness of Breath	_____	Indigestion	_____
Fatigue	_____	Belching	_____
Depression	_____	Vomiting	_____
Lights Bother Eyes	_____	Shoulder Pain	_____
Loss of Memory	_____	Swelling Joints	_____
Ears Ring	_____	Knee Pain	_____
Face Flushed	_____	Hay fever	_____
Buzzing in Ears	_____	Menstrual Difficulties	_____

Check each of the activities which helps relieve your condition:

_____	Sleeping	_____	Home Exercise Equipment
_____	Hot Water Bottle	_____	Lying Down
_____	Heating Pads	_____	Hot Baths
_____	Pain Relief Gel	_____	Ice Pack
_____	Swimming	_____	Exercising
_____	Sauna	_____	Strengthening
_____	Whirlpool	_____	Steam Room
_____	Sitting	_____	Walking
_____	Over Counter Medicine	_____	Sitting in Recliner
_____	Home Traction	_____	Prescription Drugs

FAMILY HEALTH HISTORY

Many health problems are hereditary in nature and may be handed down generation after generation.

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply.

CONDITION	Father	Mother	Brothers	Sisters
Arthritis				
Asthma – Hay Fever				
Back Trouble				
Bursitis				
Cancer				
Constipation				
Diabetes				
Disc Problem				
Emphysema				
Epilepsy				
Headaches				
Heart Trouble				
High Blood Pressure				
Insomnia				
Kidney Trouble				
Liver Trouble				
Migraine				
Nervousness				
Neuritis				
Neuralgia				
Pinched Nerve				
Scoliosis				
Sinus Trouble				
Stomach Trouble				

If any of the above family members are deceased please list their age at death and cause: _____

_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

By signing this, I consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described in the notice of information practices.

X _____

Signature of patient or Legal Representative Date

OFFICE POLICY
REGARDING INSURANCE ASSIGNMENT

We prefer the patient PAY IN CASH each office visit. However, we will extend you the courtesy of benefits assigned, but the balance of what the insurance company has not paid, has to be paid each visit or at the end of the week. If after 45 days we do not hear from your insurance company, you are responsible for the balance.

WE DO NOT get into dispute or arbitration with any insurance company, or any other involved party that is YOUR responsibility.

Office policy regarding insurance assignment:

1. Our office does NOT guarantee, nor does your insurance carrier guarantee, payment of benefits. **It is your responsibility at the beginning of your health care to receive verification of your policy and what it covers. However, if your insurance claim is denied, you are responsible for balance due.**

2. You are required to know the limits of your policy and if they have been met for the current anniversary year. Any balance above policy limits is your responsibility.

3. If your insurance carrier requires a referral or any other authorization of treatment form, it is your responsibility to obtain one or pay any resultant balance.

4. We will accept assignment after your insurance has been verified. You are required to pay any balance.

5. If you discontinue care, the balance of your account is due and payable IN FULL IMMEDIATELY.

6. Your insurance should pay within 30 days. If your insurance has not paid within 45 days, you must pay the balance due.

7. If your insurance carrier issues payment directly to you it is your responsibility to send payment along with a copy of the explanation of benefits to this office.

8. You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance company on your first office visit.

9. **Our office will NOT enter into a dispute with your insurance company, or any other party involved with your claim. This is your responsibility and obligation.**

***IF YOU UNDERSTAND AND AGREE WITH ALL OF THE ABOVE OFFICE POLICIES, PLEASE SIGN YOUR NAME BELOW AND WE WILL ACCEPT YOUR INSURANCE ASSIGNMENT.**

X _____

DATE **SIGNATURE OF PATIENT**

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various therapeutic procedures, such as hot or cold packs, traction, electric muscle stimulation, ultrasound or others may be used. Also, supports, nutritional advice, and homecare instructions (to include exercises) may be utilized to enhance recovery.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon injury to arteries of the neck. Some patients may notice stiffness or soreness after treatment. The therapeutic procedures could produce skin irritation, burns or minor complications. Exercise could cause sprains/strains and exacerbate your condition. Nutritional supplements could cause sensitivities, allergic reactions, pain, discomfort, bruising, discoloration, pregnancy risks, emotional upset and aggravation of preexisting symptoms. There can also be incompatibilities with medications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare." The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to therapeutic procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to communicable disease.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a number of cases.

Risks of non-treatment: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. There is also the possibility of permanent and irreversible damage.

Unusual risks: *I have had the following unusual risks of my case explained to me:*

_____

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

X _____

Printed Name Signature Date

WITNESS:

_____

Printed Name Signature Date

PREFERRED CONTACT METHOD

Name _____

*Please note that we will no longer communicate through the mail unless this is the only option.

Please indicate how you would like us to correspond with you by placing a number (1, 2, and 3) next to each option below. **1=Primary 2=Secondary 3=Tertiary**

____ **Text** *(provide best cell number)* _____

____ **Email** *(provide best email address)* _____

____ **Phone** *(provide best phone number)* _____

Signature X _____