



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:

- | | | | | |
|---|-------------------------------------|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chorea | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever | |

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

- | | | | | |
|---|--|--|--|---|
| <p><u>General</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergy <input type="checkbox"/> Chills <input type="checkbox"/> Convulsions <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Depression <input type="checkbox"/> Neuralgia <input type="checkbox"/> Sweats <input type="checkbox"/> Tremors | <p><u>Muscle & Joint</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Foot trouble <input type="checkbox"/> Hernia <input type="checkbox"/> Low back pain <input type="checkbox"/> Lumbago <input type="checkbox"/> Neck Pain <input type="checkbox"/> Shoulder Pain <p>Pain or numbness in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shoulders <input type="checkbox"/> Arms <input type="checkbox"/> Elbows <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Knees <input type="checkbox"/> Feet <input type="checkbox"/> Tailbone <input type="checkbox"/> Poor Posture <input type="checkbox"/> Sciatica <input type="checkbox"/> Spinal Curvature <input type="checkbox"/> Swollen joints | <p><u>Eyes, Ears, & Nose</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Colds <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Deafness <input type="checkbox"/> Dental Decay <input type="checkbox"/> Ear Ache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Ear Noises <input type="checkbox"/> Enlarged glands <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Eye pain <input type="checkbox"/> Failing vision <input type="checkbox"/> Far sightedness <input type="checkbox"/> Gum trouble <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Near sightedness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Sore throat <input type="checkbox"/> Tonsillitis | <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Chronic cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Wheezing <p><u>Gastro-intestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Belching or gas <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Colon trouble <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficult Digestion <input type="checkbox"/> Gall Bladder trouble <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Jaundice <input type="checkbox"/> Liver trouble <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pain <input type="checkbox"/> Poor appetite <input type="checkbox"/> Vomiting <input type="checkbox"/> Rectal pain | <p><u>Skin</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Hives or allergy <input type="checkbox"/> Itching <input type="checkbox"/> Rashes <input type="checkbox"/> Varicose Veins <p><u>Genito-urinary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bed wetting <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Bladder control <input type="checkbox"/> Kidney infection <input type="checkbox"/> Painful urination <input type="checkbox"/> Prostate trouble <p><u>Women Only</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cramps <input type="checkbox"/> Excessive flow <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular cycles <input type="checkbox"/> Menopause <input type="checkbox"/> Painful Flow <input type="checkbox"/> Vaginal Discharge |
|---|--|--|--|---|

	Yes	No
Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a cane or other support?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now take vitamins or minerals?	<input type="checkbox"/>	<input type="checkbox"/>

Habits:

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of Last:

	< 6 months	6-18 months	>18 months	Never
Spinal Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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



Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____ / _____