

CONFIDENTIAL CASE HISTORY FILE

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Date: _____

Full Legal Name: _____ Name you prefer: _____

Address: _____ City/State/Zip _____

Phone: (home) () _____ (work) () _____ Soc Sec# _____ - _____ - _____

Birth date: _____ / _____ / _____ Age: _____ Sex: _____ Marital Status: S M W D Sep

Spouse's Name: _____ # Children _____ Years of Education _____

Emergency Contact: _____ Phone: () _____

Your Employer: _____ Phone: () _____

Employer's Address: _____ City/State/Zip _____

Job title: _____ Supervisor Name: _____

e-mail address: _____ Referred by: _____

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

List all current over-the-counter and prescription medications used (include reason used):

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

Have you been under a physician's care in the past year? no yes (reason) _____

When was your last physical examination? _____ Dr: _____

Have you ever been under chiropractic care? no yes (describe) _____

If female, is there a possibility that you are pregnant? no yes

Do you smoke/use tobacco? no yes Exercise habits? never occasional frequent

Check any of the following symptoms you have noticed: (= Previously, = Now)

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sensitive to light or sound |
| <input type="checkbox"/> Dizziness or light-headed | <input type="checkbox"/> Leg/foot numbness/tingling | <input type="checkbox"/> Visual or hearing disturbance |
| <input type="checkbox"/> Jaw pain, clicking, or locking | <input type="checkbox"/> Leg/foot fatigue/weakness | <input type="checkbox"/> Memory loss/problems |
| <input type="checkbox"/> Pain or difficulty swallowing | <input type="checkbox"/> Leg pain with walking | <input type="checkbox"/> Irritability or depression |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Fatigue or loss of energy |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Fainting or convulsions |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Diarrhea or constipation | <input type="checkbox"/> Trouble with balance or coordination |
| <input type="checkbox"/> Chest pain or cough | <input type="checkbox"/> Blood in urine or stool | <input type="checkbox"/> Sleep disturbances/problems |
| <input type="checkbox"/> Pain/trouble breathing | <input type="checkbox"/> Difficulty or pain w/ urination | <input type="checkbox"/> Rashes (face, body, limbs) |
| <input type="checkbox"/> Arm/hand numbness/tingling | <input type="checkbox"/> Difficulty with sexual function | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Arm/hand fatigue/weakness | <input type="checkbox"/> Abnormal menstrual periods | <input type="checkbox"/> Pain with exertion (activity, climbing stairs, etc.) |

HAVE YOU HAD ANY OF

THE FOLLOWING:

NOW:

- Pain worse at night
- Constant pain
- Unexplained weight loss

Recent bacterial infection (30 days)

- Loss of bowel or bladder control
- Urinary discharge
- Recent surgery (30 days)

EVER:

- History of cancer
- History of IV drug use
- History of blood transfusion

Information about your current condition/complaints

What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: Constant Intermittent

Is your condition getting worse? _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____
2. _____
3. _____

Have you had: Xray MRI or CAT Scan EMG Bone Scan Blood Work

Who is your family medical doctor: _____

List all home remedies tried for this problem: _____

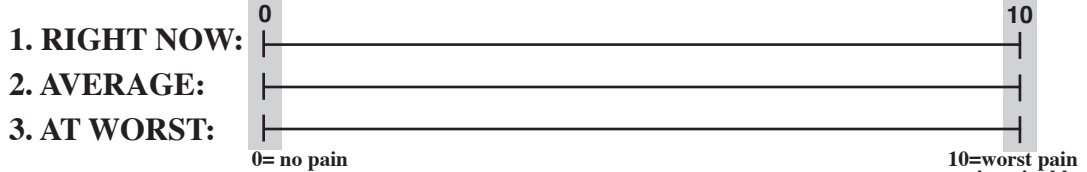
Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) work _____ sleep _____ normal daily routine _____

Have you had symptoms like this before? no yes (describe) _____

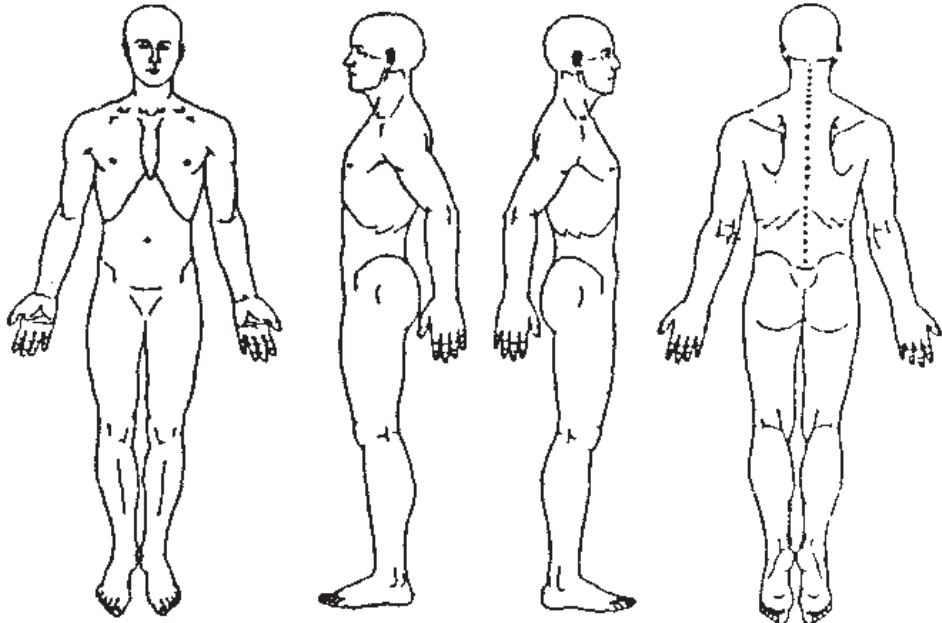
Regarding your main complaint:

How bad is your pain?
 (make a slash on all 3 scales)



Draw the area of your symptoms using these symbols:
 (mark on the figures)

- XXX = ache
- * = sharp/stab
- ooo = numb/tingle
- = shooting
- //// = stiff/tight



NOTICE TO NEW PATIENTS: Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.

Patient Signature: _____ Date _____

INFORMED CONSENT

Before beginning treatment, it is our office policy to inform you of what to expect, possible complications of chiropractic, as well as complications of other approaches. Remember that all forms of treatment (including non-treatment!) have associated risks. **If you have any questions, please ask the doctor.**

What to Expect

The treatment at our office will consist of manipulation of the joints and soft tissues, using the hands and/or a mechanical instrument. You may feel joint movement, and you may hear joint clicks or other noises. Physical therapy methods, along with therapeutic exercise may also be used.

Chiropractic Risks

Chiropractic treatment is one of the safest methods of treating back pain. Still, unexpected problems can occur. Minor, temporary problems, such as soreness and stiffness can occur, especially in the beginning of a treatment plan. Slightly more serious problems are local burns from heat generating physical therapy equipment. More significant problems, such as fracture of weakened bone or sprain/disc injuries are rare. A stroke following neck manipulation is an extremely rare complication, occurring less than 1 per million treatments. Stroke has also been the result of ordinary activities, such as head turning or stargazing.

Other Treatments and Risks

Medications: Many commonly used medications, such as NSAIDs (e.g. Advil, Aleve) or Tylenol, carry risks of tissue damage, including stomach ulcers or kidney damage. This damage can occur quickly, and may be irreversible. There is a significantly higher risk of developing a serious complication with NSAIDs as opposed to chiropractic. Other medications are habit-forming, and may mask pain to allow further tissue damage.

Surgery: surgery is the treatment of choice in less than 1% of back pain patients. Your doctor has screened for surgical "red flags", and will refer you for a surgical opinion if indicated. Clinical results of surgery for mechanical back pain have been disappointing, and expose you to unnecessary hospital and medication risk.

Rest/non-treatment: Bed rest has been shown to increase the likelihood of re-occurrence of back episodes, and make chronic pain more likely. Likewise, non-treatment may cause a permanent mechanical problem to develop, causing future back problems.

I have read the above, and give my consent to begin chiropractic treatment.

Printed Name _____ Date _____

Signature _____

FINANCIAL POLICY

Medicare Patients

Medicare is your primary insurance company. We will bill Medicare from our office. Medicare will pay only for services that determines that be "reasonable and necessary". If Medicare determines that a particular service is not "reasonable and necessary" under Medicare standards, Medicare will deny payment for that service.

Current Medicare regulations will not reimburse for the following services: exams, physical therapy, x-rays, supports. Although they will usually pay for treatments, they may not pay for this many treatments overall, or within a certain period of time. Non-covered services will be charged directly to you and you will be responsible for payment.

Auto Accident patients

If you have PIP coverage: we will bill your insurance carrier directly. If the accident was not your fault, this will not raise your rates or cost your company any money. These carriers usually pay 100% of billed charges. If your carrier does not, we will notify you.

Workers Compensation patients

We will bill the workers compensation carrier. In an accepted claim, insurance pays 100% of all charges. If your claim is not accepted you will be responsible for any charges for services rendered on your behalf.

Cash Patients

Payment for services is expected that in time of service. The receptionist will discuss fees with you. A 20% discount will be given for payment at the time of service.

Health Plans of

We will bill your insurance company for you.

If your plan is a managed care plan, and requires a physician referral, we will help you obtain one. However, the responsibility for this referral lies with you. If your plan requires pre-authorization, we will work to obtain this on your behalf.

If your plan requires a co-pay or a deductible, we expect this to be paid at the time of service.

Please ask the receptionist if you are not sure of any of these items.

Signed _____

Please see other side

Date _____