

Chiropractic Case History/Patient Information

Date: _____ **Patient #** _____ **Doctor:** _____
Name: _____ **Home Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
E-mail address: _____ **Fax #** _____ **Cell Phone:** _____
Cell Phone Carrier: _____ **Is it ok to give you office visit reminders via: text () email ()**
Age: _____ **Birth Date:** _____ **Race:** _____ **Marital:** M S W D
Occupation: _____ **Employer:** _____
Employer's Address: _____ **Office** _____ **Phone:** _____
Spouse: _____ **Occupation:** _____ **Employer:** _____
How many children? _____ **Names and Ages of Children:** _____

Emergency Contact: _____ **Address:** _____ **Phone:** _____
How were you referred to our office? _____
Family Medical Doctor: _____

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

Please check any and all insurance coverage that may be applicable in this case:
 Major Medical Worker's Compensation Medicaid Medicare Auto Accident
 Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

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 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. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____ **Date:** _____
Guardian's Signature Authorizing Care: _____ **Date:** _____

PATIENT NAME _____
DATE _____ **Doctor** _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto ___ Work ___ Other _____

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: _____

Do you have a history of stroke, clots, or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

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? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

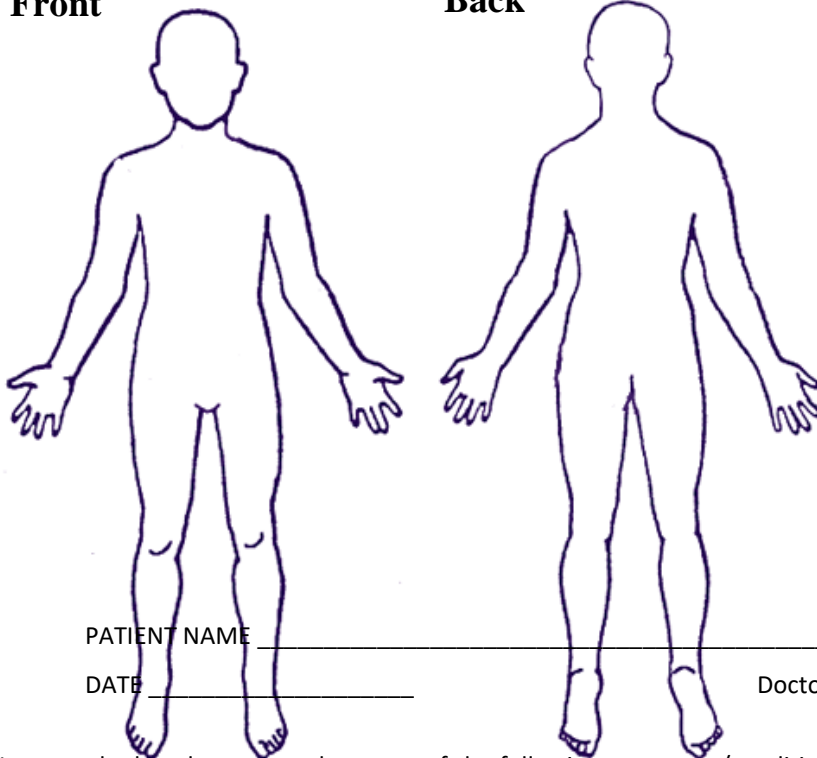
If yes, describe: _____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

Front

Back



Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these

conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously
Headaches _____ Frequency _____		Loss of Balance _____
Neck Pain _____		Fainting _____
Stiff Neck _____		Loss of Smell _____
Sleeping Problems _____		Loss of Taste _____
Back Pain _____		Unusual Bowel Patterns _____
Nervousness _____		Feet Cold _____
Tension _____		Hands Cold _____
Irritability _____		Arthritis _____
Chest Pains/Tightness _____		Muscle Spasms _____
Dizziness _____		Frequent Colds _____
Shoulder/Neck/Arm Pain _____		Fever _____
Numbness in Fingers _____		Sinus Problems _____
Numbness in Toes _____		Diabetes _____
High Blood Pressure _____		Indigestion Problems _____
Difficulty Urinating _____		Joint Pain/Swelling _____
Weakness in Extremities _____		Menstrual Difficulties _____
Breathing Problems _____		Weight Loss/Gain _____
Fatigue _____		Depression _____
Lights Bother Eyes _____		Loss of Memory _____
Ears Ring _____		Buzzing in Ears _____
Broken Bones/Fracture _____		Circulation Problems _____
Rheumatoid Arthritis _____		Seizures/Epilepsy _____
Excessive Bleeding _____		Low Blood Pressure _____
Osteoarthritis _____		Osteoporosis _____
Pacemaker _____		Heart Disease _____
Stroke _____		Cancer _____
Ruptures _____		Coughing Blood _____
Eating Disorder _____		Alcoholism _____
Drug Addiction _____		HIV Positive _____
Gall Bladder Problems _____		
Ulcers _____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
 OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify) _____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	_____

OTHER INFORMATION

How do you sleep: _ Back _ Side _ Stomach
 Do you use a pillow : _ Yes _ No
 Do you wear orthotics or arch supports _ Yes _ No

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age []	MOTHER Age []	SPOUSE Age []	BROTHER(S) Age [] Age []	SISTERS Age [] Age []	CHILDREN Age [] Age []
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

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

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft

tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology.

The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely. To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient _____ Date _____

Signature of Parent or Guardian _____ Date _____ (if a minor)

Signature of Witness _____ Date _____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a \$20 charge for a cancellation or no-show without proper notice. This charge will not be covered by you insurance, but will have to be paid by you personally.

For Workmen's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

You may occasionally need to see another physician in our office other than the one who normally sees you if you do need to re-arrange your appointment. All of our physicians are experienced professional and they will study your chart. You may return to your original physician at the next appointment.

Please understand that your pain will probably increase and decreases as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason not to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2) The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

Patient Signature

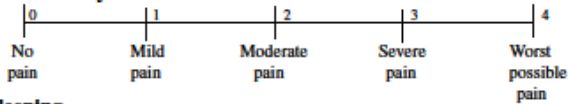
Date

Functional Rating Index

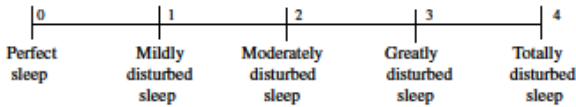
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

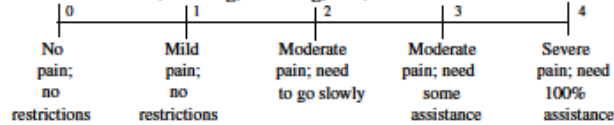
1. Pain Intensity



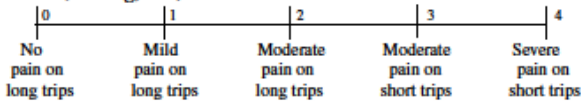
2. Sleeping



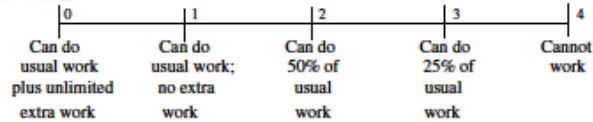
3. Personal Care (washing, dressing, etc.)



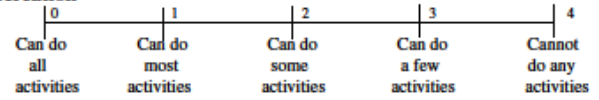
4. Travel (driving, etc.)



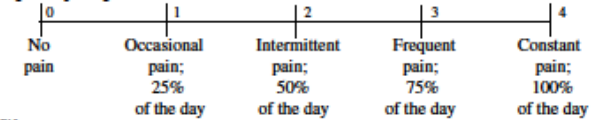
5. Work



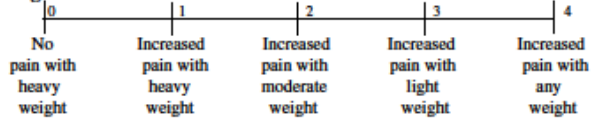
6. Recreation



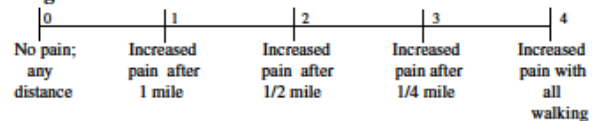
7. Frequency of pain



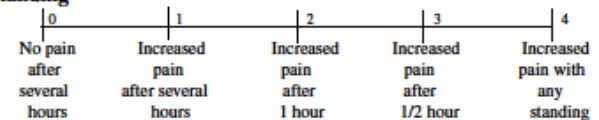
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date

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