CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name_____ Date of Birth_____ Sex: M F

Address_____ City_____ Zip_____

Home Phone_____ Cell_____ E-mail_____

Marital Status: S M D W Spouse's Name_____ Children, Ages _____

Occupation_____ Employer_____

Who referred you to us?_____ How else did you hear about us?_____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your:☐ Work ☐ Sleep ☐ Daily Routine ☐ Other:_____

List any other doctors seen for this: _____

Are you currently taking medication?___Yes ___No. List medications:_____

_____

List the approximate dates of any surgery or treated conditions: _____

_____

Have you been in an auto accident or had any other personal injury?

___Yes ___ No. Please describe_____

Family History

Please list any health conditions as well as ages of family members.

Father: _____

Mother: _____

Brother/s and Sister/s: _____

Please complete the following pages. Thank You.

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HEALTH REPORT

Reason for seeking care: _____

List any type of treatment received for this condition:
_____

Have you had similar accidents or injuries before? ___ Yes ___ No If yes, explain:
_____

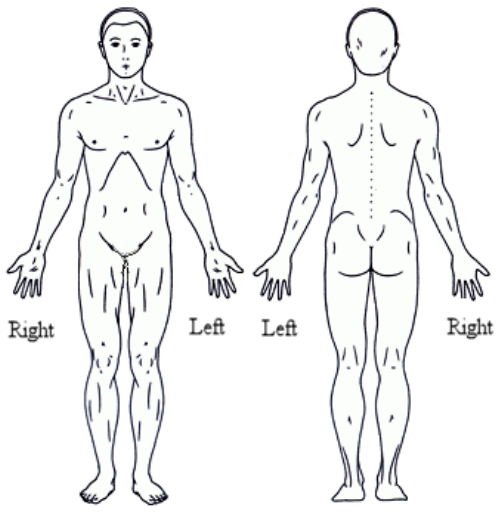
Do you have any relatives with a similar condition Y/N relation: _____

Have you received chiropractic treatment previously? ___ Yes ___ No
If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____

Do you smoke Y/N ____ Alcohol Y/N ____Daily ____Weekly ____Social ____ Occasional
Caffeinated drinks per day _____

Do you take Vitamins/Supplements Y/N ____ If yes, list types and how often
_____



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other	^ ^ ^

Is this condition worse during certain times of the day? Y/N

Patient Name:_____
Date:_____

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Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient
Signature_____Date_____
_____

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INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand the neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications. An undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather, I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic healthcare and physical therapy, which includes, rarely, but not limited to; fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or have been explained of the above information regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend for this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____

Patient's Name (Print): _____

Patient's Signature: _____ Date: _____

Relationship if not signed by parent: _____

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How your health information may be used:

- To provide treatment: We will use your health information within out office to provide you with the best health care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between physician and staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other healthcare personnel providing you treatment.
- **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent in electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.
- **To conduct healthcare operations:** Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, business and clinical employees. It is also 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. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities,
- **In patient reminders:** Because we believe regular care is very important to your general health, we remind you of a scheduled appointment. Additionally, we may contact you to follow up on you care and inform you of treatment options or services that may be of interest to you or your family.
- **Abuse or Neglect:** We will not notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.
- **Public Health and National Security:** We may be required to disclose to federals officials or military authorities health information necessary to complete an investigation related to public health or national security.
- **For law enforcement:** As permitted or required by state or federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes.
- **Family, Friends, and Caregivers:** We may share your health information with those you tell us will be helping you with you home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will

use our very best judgment when sharing your health information only when it will be important to those participating in your care.

- **To Coroners, Funeral Directors, and Medical Examiners:** We may be required by law to provide information to coroners, funeral directors, and medical examiners for the purposes of determining a cause of death and preparing a funeral.

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Name _____ DOB _____
Signature _____ Date_____