Chiropractic Case History/Patient Information

Date:_____ Patient #_____ Doctor:_____

Name:_____ Social Security #_____ Home Phone: _____

Address:_____ City:_____ State:_____ Zip:_____

E-mail address:_____ Fax #_____ Cell Phone:_____

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:_____

_____

Name of Nearest Relative:_____ 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 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?_____

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	

PATIENT NAME _____

DATE _____ Doctor_____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
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

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor _____

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 _____

PATIENT SPECIFIC FUNCTIONAL AND PAIN SCALES (PSFS)

Name_____ Date_____

In your visits here we want to know what 3 activities in your life you are unable to do or having the most difficulty with as a result of your chief problem.

Please list 3 activities you are unable to perform or having the most difficulty with because of your chief problem.

1._____

2._____

3._____

Activity #1

(Circle one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity — Able to perform activity as same level as before injury or problem

Activity #2

(Circle one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity — Able to perform activity as same level as before injury or problem

Activity #3

(Circle one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity — Able to perform activity as same level as before injury or problem

Our goal is to work together with you to "problem-solve" ways to return you to the activities which you have told us you are either unable to perform or are giving you the most difficulty since this problem began.

Chatman AB, Hyams SP, Neel JM, Binkley JM, Stratford PW. Schomberg A, Stabler M. The patient-specific functional scale: Measurement properties in patients with knee dysfunction. Phys Ther 1997;77:820-829

Fisher Family Chiropractic, S.C.

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Chiropractic Rehabilitation and Wellness Care for Families

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information...

1. For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
2. For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.
3. For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in the case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subjected to re-disclose by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, or privacy practices, or any aspect of our privacy activities, you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the "NOTICE OF PRIVACY PRACTICES" binder in reception area or ask for a copy at the Front Desk.

Name (printed) _____ Signature _____ Date _____

If you are a minor, or if you are being represented by another party:

Personal Representative (printed) _____ Personal Representative Signature _____ Date _____

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INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic of office listed above or any other office or clinic.

X-rays are taken for observation of spinal alignment and degenerative changes only. If you wish to have a radiologist interpret them to determine if any other findings are present the cost is $30.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-names procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date_____
Witness Signature_____ Date_____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

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