INTRODUCTION PATIENT CASE HISTORY

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Name: (First MI Last) Address:				7in:
	Gender: Male Female	Social Security #:		
Date of Birth: Mome:				
		work:	andrian to appear of the	
Email:		Name II VIII III	1 Othoru	
Preferred Method of Contact:	□ 1ext □ Email □ 1	Phone - Home, Mobile, or Wo	rk Other.	
*Referred By: (Name)				
· •	Co-Worker Doctor			
Race & Ethnicity: (Choose up to 2)	Preferred 1		user were soon was soon was not	, was not use the size that the size on the size of t
☐ African American or Black	☐ Englis			
☐ American Indian or Alaskan	Native Spanis	h		
□ Asian	☐ Other:			
☐ Hispanic or Latino	□ Declin	e		
☐ Native Hawaiian or Other Pa	acific Islander			
□ White				
1'				
☐ Decline				
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MERGENCY CONTACT INFORMATION Name: (First MI Last) Home:N Relationship: □ Child □ Parent □ Spous	Mobile:	Primary Care Phys Doctor's Phone:	ician:	
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HISTORY OF PRESENT ILLNESS

Major Complaint:	Sec	Secondary Complaints:		
When did it start?/ Wh	at happened?			
Which daily activities are being affected b	oy this condition?			
w w m m m m m m m m m m m m m m m m m m	Major Compl	AINT		
Location of Symptoms and Radiation	Quality:	Previous Treatment:		
	☐ Sharp	□ None		
	☐ Stabbing	☐ Chiropractor		
	☐ Burning	☐ Medical Doctor		
	□ Achy	☐ Physical Therapy		
當一一節	□ Dull	☐ ER/Urgent Care		
	□ Stiff & Sore	Orthopedic		
	Other:	☐ Other:		
R L L R	Does it radiate?	Previous Diagnostic Testing:		
R L L R	☐ No ☐ Yes (Please indic	ate on drawing) None		
	Improves with:	□ X-rays		
P Pain T Tender N Numb H Hypoesthesia	☐ Ice	□ MRI		
S _ Spasm	☐ Heat	□ CT		
Grade Intensity/Severity:	☐ Movement	Other:		
None (0/10)	☐ Stretching	*Women: Are you pregnant?		
☐ Mild (1-2/10)	OTC Medications:	No Last Menstrual Period://		
☐ Mild-Moderate (2-4/10)	☐ Other:	☐ Yes Due date://		
☐ Moderate (4-6/10)	Worsens with:	Present Illness Comments:		
☐ Moderate-Severe (6-8/10)	☐ Sitting			
□ Severe (8-10/10)	☐ Standing/Walking			
Frequency:	☐ Lying Down/Sleeping	· · · · · · · · · · · · · · · · · · ·		
□ Off & On	☐ Overuse/Lifting			
□ Constant	Other:			
Prescription Medications & Supplements	s: \square None A	llergies to Medications: □ No known drug allergies		
Yes (List - Name, dosage, frequency)		Yes (List - Name and reaction)		
	L			



PAST, FAMILY, AND SOCIAL HISTORY

Illnesses: Asthma		Hospitalizations: (Non-surgical with Date)					ical wit	Medical History Comments:		
☐ Autoimmune Disorder (17)	pe)			·						
☐ Blood Clots					2000 (76		. 1	0		
Cancer (Type)			Surgeries: (If yes, provide t							
☐ CVA/TIA (stroke)☐ Diabetes			☐ Cancer							· · · · · · · · · · · · · · · · · · ·
☐ Migraine Headaches			□ Orthopedic Shoulder – R				R/I			
☐ Osteoporosis			Elbow/Forearm – F				R / L			
Other:				1	Wrist/I	Iand –	R/L			
						Hip -	- R / L			
					K	lnee –	R/L			
Injurios							R/L			
Injuries: □ Back Injury					nal Su					
☐ Broken Bones				I.	Neck:	Maria Productiva (Primary)				
☐ Head Injury										
□ Neck Injury				Otl	ner:					
□ Falls										
Other:									- Not 200 200 200 200 200 200 200 200 200 20	
	ner	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3]	History Comments:
	7			-	THE RESERVE OF THE PARTY OF THE	-	2235			
	Mother	Fat	Sibl	Sib	Sib	Ċ	Ò	៦		a paragraphy and a surface and
Gender	F Wot	M Fat	Sibl	Sib	Sib	Ö	Ò	5		
Gender Age at death (if Deceased)			Sibl	Sib	Sib	ð	ō	5		
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Today's Date: _____ Patient Name: _



REVIEW OF SYSTEMS

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you <u>currently</u> experiencing any of these symptoms? (Please select all that apply and use comments to elaborate.)

Constitutional: (General)	Respiratory:	Review of Systems Comments:
□ Fever	☐ Difficulty Breathing	
☐ Fatigue		
☐ Other:	☐ Other:	
☐ None in this Category	☐ None in this Category	
Musculoskeletal:	Eyes & Vision:	
☐ Joint Pain/Stiffness/Swelling	☐ Eye Pain	
☐ Muscle Pain/Stiffness/Spasms	☐ Blurred or Double Vision	
Broken Bones	☐ Sensitivity to Light	
☐ Other:	☐ Other:	
□ None in this Category	☐ None in this Category	
Neurological:	Head, Ears, Nose, & Mouth/Throat:	
☐ Dizziness or Lightheaded	☐ Frequent or Recurrent Headaches	
☐ Convulsions or Seizures	☐ Ear - Ache/Ringing/Drainage	
Tremors	☐ Hearing Loss	
□ Other:	☐ Sensitivity to Loud Noises	
☐ None in this Category	☐ Sinus Problems	
Psychiatric: (Mind/Stress)	☐ Sore Throat	
■ Nervousness/Anxiety	☐ Other:	
☐ Depression	☐ None in this Category	
☐ Sleep Problems	Endocrine:	
☐ Memory Loss or Confusion	☐ Infertility	
☐ Other:	☐ Recent Weight Change	
□ None in this Category	☐ Eating Disorder	
5 •	☐ Other:	
Genitourinary:	□ None in this Category	
☐ Frequent or Painful Urination		
☐ Blood in Urine	Hematologic & Lymphatic:	
☐ Incontinence or Bed Wetting	☐ Excessive Thirst or Urination	
 Painful or Irregular Periods 	☐ Cold Extremities	
☐ Other:	☐ Swollen Glands	
☐ None in this Category	Other:	
Gastrointestinal:	☐ None in this Category	
☐ Loss of Appetite	Integumentary: (Skin, Nails, & Breasts)	
☐ Blood in Stool or Black Stool	☐ Rash or Itching	
☐ Nausea or Vomiting	☐ Change in Skin, Hair, or Nails	
☐ Abdominal Pain	 Non-healing Sores or Lesions 	
☐ Frequent Diarrhea	☐ Change of Appearance of a Mole	
☐ Constipation	☐ Breast Pain, Lump, or Discharge	
☐ Other:	☐ Other:	
☐ None in this Category	□ None in this Category	
Cardiovascular & Heart:	Allergic/Immunologic:	
☐ Chest Pains/Tightness	☐ Food Allergies	
☐ Rapid or Heartbeat Changes	☐ Environmental Allergies	
☐ Swelling of Hands, Ankles, or Feet	Other:	
☐ Other:	☐ None in this Category	
□ None in this Category		
•	my knowledge and certify them to be true and correc	Date
ratient or Guardian Signature		Date



TERMS OF ACCEPTANCE

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION FOR CONSULTATION AND EXAMINATION: The consultation involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health conditions. This will help to determine if chiropractic services are appropriate. If appropriate, after the consultation, a physical examination will be performed that can include but is not limited to: vitals measurement, systems evaluation, orthopedic tests and maneuvers, neurological test, as well as physical touching. These tests and maneuvers will help the chiropractor to determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below you authorized this office/ provider to complete a consultation and examination on the above patient.

AUTHORIZATION FOR X-RAY WITH RELEASE: X-rays may be taken to help the chiropractor analyze the underlying condition, alignment of the spine, and associated structures. By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x- rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/ provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

HIPAA ACKNOWLEDGEMENT: I have reviewed the HIPAA notice of privacy practices, have been provided an opportunity to discuss my right to privacy, and know that upon request I will be given a copy.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider during the intake process are a true and accurate to the best of your knowledge.

Patient Name	Patient Signature	Date
Parent/Guardian Name	Parent/Guardian Signature	Date

INFORMED CONSENT TO CARE

- 1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound. Certain techniques may require close proximity between clinician and patient.
- 2. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations.
- 3. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury. The possible consequences and possible complications have been explained to me by the chiropractor.
- 4. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment.
- 5. I have been afforded ample opportunity for questions and answers.
- 6. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations.

TREATMENT OPTIONS:

It is also important that you understand there are treatment options available for your condition other than chiro-practic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case. It is common for examination and treatment procedures to involve contact with the pelvic area, e.g. sacrum, coccyx (tailbone), sacrotuberous and inguinal ligaments, superior aspect of the pubic tubercle and symphysis, and surrounding musculature. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location. Exposer to these same areas may be necessary for better results, but not without your verbal agreement at the time. Please be aware that a third party staff observer will not be present during these procedures.

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

YOUR UNDERSTANDING AND AGREEMENT:

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition for which I seek care from this office.

Patient Name	Patient Signature	Date
Parent/Guardian Name	Parent/Guardian Signature	Date

