Patient Case History

Patient Name_____ Date:_____

PERSONAL INFORMATION

Date of birth:____/____/_____ Age:_____ Sex: ☐ Male ☐ Female Marital Status: S / M / D / W

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

Social Security #:_____ Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Occupation:_____ Employer:_____

Spouse's Name:_____ Date of birth:____/____/_____ Age:_____

Emergency Contact:_____ Phone Number: (_____) _____ - _____

Who Referred you to us?:_____

How Else Did You Hear About Us?:_____

CURRENT PRIMARY HEALTH CONCERN

Describe the condition you're

experiencing:_____

_____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No If Yes, When: _____

What position(s), if any, make it feel worse? _____

What position(s), if any, make it feel better? _____

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

What do you think caused this condition? _____

Is this condition: ☐ Improving ☐ Unchanged ☐ Getting Worse?

Other Physicians or Therapists who have treated ***this*** condition: _____ When: _____

Describe any treatment you have had for ***this*** condition (include medication dosage and frequency)?:_____

_____

_____

Family Medical Doctor:_____ Address:_____ Date of Last Physical:_____

May we communicate our findings on your current health condition to the above provider(s)? ☐ Yes ☐ No

OTHER HEALTH COMPLAINTS:

Please list the specific complaints you are experiencing at this time. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort and 10 being the most discomfort.

Primary Complaint:_____ 1 2 3 4 5 6 7 8 9 10

2) _____ 1 2 3 4 5 6 7 8 9 10

3) _____ 1 2 3 4 5 6 7 8 9 10

4) _____ 1 2 3 4 5 6 7 8 9 10

Dr. Signature: _____

Patient Name_____ Date:_____

PREVIOUS CONDITIONS

List all current medications and their dosage. ☐ None

_____

_____

List any known allergies you have. ☐ None

_____

_____

List any surgical operations and years. ☐ None

_____

_____

Have you been diagnosed with Hypertension? ☐ Yes ☐ No Diabetes? ☐ Yes ☐ No

CHIROPRACTIC HISTORY

Previous Chiropractic Care? ☐ Yes ☐ No If yes, Doctor's Name:_____

Date of last chiropractic visit: _____ _____ _____ Date of last diagnostic imaging: _____ _____ _____

Reason for care:_____ How long were you under care?:_____

Were you satisfied with the previous chiropractic care that you received? ☐ Yes ☐ No

SOCIAL HISTORY

Height: _____ft. _____in. Current Weight: _____ Have you recently lost or gained weight? ☐ Lost ☐ Gained

Mental Work: ☐ Heavy ☐ Moderate ☐ Light Hours Per Day: _____

Physical Work: ☐ Heavy ☐ Moderate ☐ Light Hours Per Day: _____

Exercise: ☐ Heavy ☐ Moderate ☐ Light Hours Per Week:_____ Type: _____

Alcohol: Beer week: _____ Liquor week: _____ Wine week: _____ # of years:_____

Smoking: ☐ Never ☐ Currently ☐ Previously Packs Day: _____ Packs Week:_____ # of years:_____

Caffeine: Coffee week: _____ Tea week: _____ Cola week: _____ # of years:_____

Over-the-counter pain killers # week: _____ Type: _____ How long: _____

FAMILY HISTORY

List any diseases or cause of death for biological parents and grandparents:

Mother _____ Father _____

Maternal Grandmother _____ Paternal Grandmother _____

Maternal Grandfather _____ Paternal Grandfather _____

Dr. Signature: _____

REVIEW OF SYSTEMS

Check all that apply now and all that have applied in the past.

Patient Name_____ Date:_____

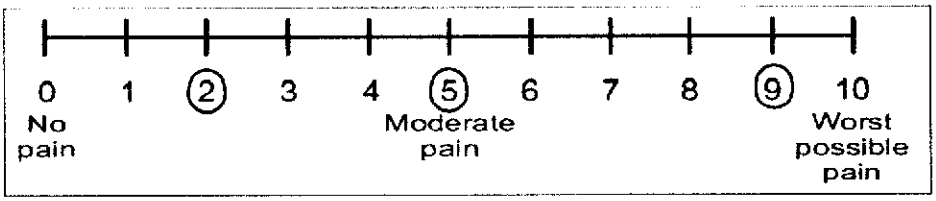
GENERAL	NOW	PAST	THROAT	NOW	PAST	GASTRO-INTESTINAL	NOW	PAST	NEUROLOGICAL	NOW	PAST
Weakness			Soreness			Abdominal Pain			Seizures		
Fatigue			Bad Tonsils			Nausea			Vertigo		
Fever			Hoarseness			Bloated			Dizziness		
Chills			Pain			Belching			Hand Trembling		
Night Sweats			Trouble Swallowing			Heartburn			Loss of Sensation		
Fainting			Recurrent Infections			Indigestion			Incoordination		
SKIN	**NOW**	**PAST**	**NECK**	**NOW**	**PAST**	Irregular Bowel Habits			Loss of Facial Control		
Color Changes			Neck Enlargement			Constipation			Weak Grip		
Nail Changes			Stiff Neck			Diarrhea			Paralysis		
Hair Changes			Soreness			Gas			Difficulty Speaking		
Moles			Lumps			Hemorrhoids			Tingling		
Rashes			Masses			Poor Appetite			Loss of Memory		
Sores			**BREASTS**	**NOW**	**PAST**	Food Intolerance			Numbness		
Weakness			Discharge			Bloody Stools			**PSYCHIATRIC**	**NOW**	**PAST**
HEAD	**NOW**	**PAST**	Lumps			Black Stools			Hyperventilation		
Headaches			Pain			**GENITOURINARY**	**NOW**	**PAST**	Insecurity		
Injuries			Bleeding			Urgency			Depression		
Bumps			Nipple Changes			Incontinence			Troubled Sleep		
Last Eye Exam			Skin Changes			Straining			Irritable		
Glasses			Bloated			Back Pain			Undecidedness		
Contacts			**LUNGS**	**NOW**	**PAST**	Frequent Voiding			Timid		
Cataracts			Cough			Stones			Hallucinations		
EARS	**NOW**	**PAST**	Phlegm			Burning			Loss of Memory		
Hard of Hearing			Blood			Bed Wetting			Alcoholism		
Deafness			Short of Breath			Small Stream			Drug Addiction		
Ringing			Wheezing			Discharge			Drug Dependency		
Discharge			Pain			Impotence			Suicidal Thoughts		
Earache			Congestion			Dribbling			Extreme Worry		
Itching			Inhalant Exposure			Cloudy Urine			Sexual Problems		
Dizziness			**HEART**	**NOW**	**PAST**	Abnormal Urine Color			**ENDOCRINE**	**NOW**	**PAST**
Room Spins			Murmur			Spotting between Periods			Weight Loss		
NOSE	**NOW**	**PAST**	Palpitations			Menstrual Cramps			Weight Gain		
Decreased Smell			Rapid Heartbeat			Discharge			Extremely Thin		
Bleeding			Swollen Extremities			Itching			Heat Intolerance		
Pain			Cold Extremities			Painful Intercourse			Cold Intolerance		
Discharge			Chest Pain/Pressure			Irregular Periods			Hair Changes		
Obstruction			Varicose Veins			Hot Flashes			Breast Changes		
Post Nasal Drip			Blood Clots			Contraception			**MOUTH**	**NOW**	**PAST**
Deviated Septum			Blue Extremities			**MUSKULOSKELETAL**	**NOW**	**PAST**	Bleeding Gums		
Runny Nose			**BLOOD**	**NOW**	**PAST**	Muscle Pain			Sores		
Sinus Congestion			Anemia			Muscle Weakness			Dental Problems		
			Low Blood Iron			Muscle Cramps			Bad Breath		
			Easy Bruising			Muscle Twitching			Loss of Taste		
			Easy Bleeding			Joint Stiffness			Dry Mouth		
			Swollen Nodes			Joint Pain			Ulcers		
			Painful Nodes						Blisters		
			Sugar in Blood								
			Red Spots								

Dr. Signature: _____

Patient Name: _____ **Pain Scale** **Date:** _____

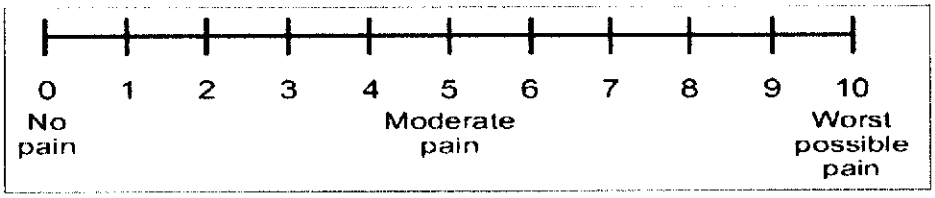
Instructions: Please circle the number that best describes the question being asked.

Example:

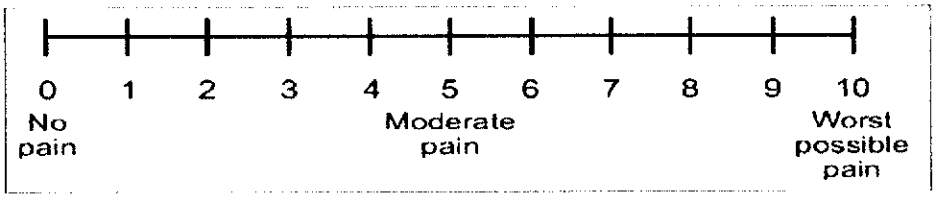


Headache **Shoulder** **Neck**

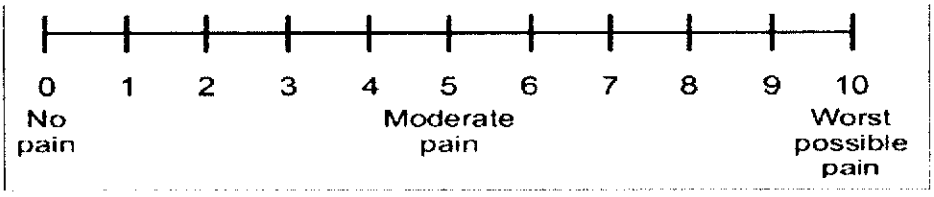
What is your pain right now?



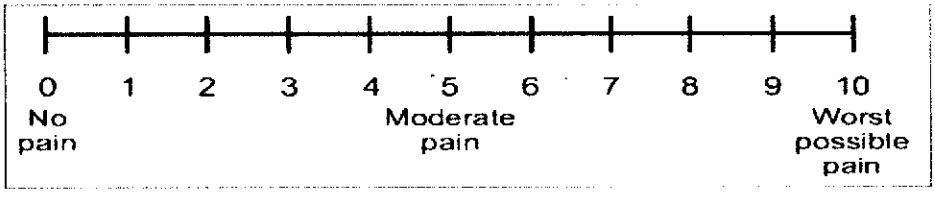
What is your typical or average pain?



What is your pain level at its best? (How close to zero does your pain get at its best?)



What is your pain level at its worst? (How close to ten does your pain get at its worst?)



Please write any further comments about your pain or discomfort below:

INFORMED CONSENT

Patient Name_____ Date:_____

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy which is the use of my hands or a mechanical instrument to move your joints. This may cause an audible "pop," and you may feel movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following: (Please initial consent for each)

___ Spinal Manipulative Therapy	___ Palpation	___ Range of Motion Testing	___ Vital Signs
___ Muscle Strength Testing	___ Orthopedic Testing	___ Postural Analysis Testing	___ Ultrasound
___ Basic Neurological Testing	___ Hot/Cold Therapy	___ Radiographic Studies	___ EMS
___ Therapeutic Exercise	___ Manual Stretching	___ Myofascial Release	___ NMR

Pregnancy

Part of the initial examination may include x-rays which are dangerous during pregnancy.

Are you now pregnant? ☐ Yes ☐ No ☐ Maybe Date of last menstrual cycle: _____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

Self-administered, over-the-counter analgesics and rest	Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers	Hospitalization	Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. There are risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. CHECK THE APPROPRIATE BOX AND SIGN BELOW

☐I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Petersen and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Printed Name: _____ Date:_____

Patient Signature: _____ Witness Signature: _____

Patient Name_____ Date:_____

Consent to Health Care Services Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on the Patient's behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by this office. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____ Initial

Patient Right to Restrict Disclosures of Protected Health Information (PHI)

For any service which you pay for 100% out of pocket, you have a right to restrict the disclosure of that health care information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ Initial

Consent to Release Information

Here at this office, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and it scollection representatives and attorneys, the following "Patient Information", medical history, diagnosis and procedures performed, course of treatment, plan of care, prognosis, supplies and or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual healthcare professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agree that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ Initial

HIPAA Privacy Notice Patient Acknowledgement

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

I hereby state that by signing this Consent I acknowledge and agree as follows:

1. The undersigned does hereby acknowledge that he or she has been offered 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 and that a copy of it is always available at the Front Desk.
2. The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. The Privacy Notice includes a complete description of the uses and or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
3. The undersigned 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.
4. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
5. The Practice's "Notice of Privacy Practices" is also provided upon request from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient Printed Name: _____ Date:_____

Patient Signature: _____ Witness Signature: _____

Financial Policy

Patient Name_____ Date:_____

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under our care.

1. **IF YOU DO NOT HAVE INSURANCE:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **IF YOU HAVE INSURANCE:** All deductibles and copayments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We are currently accepting assignment for secondary insurance carriers. Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Insurance Assignment and Release

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email and phone in regards to treatment as well as promotional activities. This clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Initial

Notice of NonCoverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment int a chiropractic office. Your insurance policy will only cover services that it deems are "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not medically necessary according to insurance guidelines: maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance, massage and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ Initial

Missed Appointment or Late Cancellation Policy

Each time a patient misses an appointment without providing **at least 24 hour notice**, another patient is prevented from receiving care. Therefore, we reserve the right to charge an **$80 fee** for all missed Massage appointments and a **$50 fee** for all missed Chiropractic/Rehab appointments which are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance. Multiple "no shows" in any 12 month period may result in termination from our practice.

Patient Printed Name: _____ Date:_____

Patient Signature: _____ Witness Signature: _____