Chiropractic Case History/Patient Information

Date:_____

PERSONAL INFORMATION

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____ Birth date: _____

Marital: M S W D Occupation:_____

Employer name, address, phone #: _____

Spouse/other:_____Occupation:_____Employer:_____

Name of person(s) we can discuss your care/account with (name, address, phone #)? _____

_____

Who may we thank for your referral to our office? _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____ If yes: Physicians name, address, phone #: _____

_____

HISTORY OF PRESENT CONDITION(S)

1) Chief Complaint(s):_____

2) Date symptoms appeared or accident happened:_____

3) Is this due to: Auto Work Other _____

4) Have you ever had the same or a similar condition? Yes No If yes, when and describe:_____

_____

5) Days lost from work:_____ Date of last physical examination:_____

6) What does this prevent you from doing or enjoying?_____

7) Has it become worse recently? Yes No If yes, when & how? _____

_____

8) How frequent is the condition? Constant (100%) Most of the time (75-99%) Intermittent (50-74%) Night Only

9) Pain Level: (Circle one) 10 9 8 7 6 5 4 3 2 1 0

10) Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Stiffness

11) What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Walking

12) Is there anything you have done that helps? Heat Massage Ice Medication Adjustments Nothing Stretching

What have you tried that has **NOT** relieved the problem? _____

_____

13) Are there any other conditions or symptoms that may be related to your major symptom? Yes No

If yes, describe: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

Rate your current and/or past menstrual cycle cramping/pain: Very strong Mild None

Circle one: 10 9 8 7 6 5 4 3 2 1 0

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
_Excessive bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

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

_____

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 allergies to any medications? Yes No

If yes, describe:_____

Do you have allergies of any kind? Yes No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

SOCIAL HISTORY

Do you drink alcoholic beverages? Yes No If so, how much per week?_____

Do you use any tobacco products? Yes No If so, packs/dips per day: _____

Do you take vitamin supplements? Yes No If so, please list:_____

Do you consume caffeine? Yes No If so, how much per day:_____

Do you exercise? Yes No If so, what is the frequency & type of exercise?_____

What are your hobbies?_____

What percentage of time during the day (at home or at work) do you spend:

Lifting_____ Sitting_____ Bending_____ Working at a computer_____

FAMILY HISTORY

Father: Living Current age: _____ Deceased Cause of death & age: _____

Mother: Living Current age: _____ Deceased Cause of death & age:_____

Are you adopted (sometimes as an adopted child, little is known of birth parents or family). Yes No

Do you have any family members who suffer from the same condition you do?

If so, please list:_____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____ Cancer____ Mental Illness____

Diabetes ____ Asthma____ Heart Disease ____

Stroke ____ Kidney Disease____ Lung Disease____

Arthritis_____ Liver Disease ____Other _____

INSURANCE **(Please present the front desk with a copy of your current insurance card(s))**

Please circle any and all insurance coverage that may be applicable in this case**:**

Major Medical Worker's Compensation Medicare Auto Accident Other

Primary Insurance: _____

Secondary Insurance: _____

Do you have a Medical Savings Account & Flex Plans? YES NO

PAYMENT RESPONSIBILITY: 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.

Signature:_____ Date:_____

INFORMED CONSENT/TREATMENT AUTHORIZATION

I, the undersigned, hereby agree to hold Dr. Pantleo and their affiliates, all associated sanctioned events and/or endorsement levels in Life Chiropractic Clinic; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands, or suits for damages from any injury or complications whatever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Wavier and Authorization to Treat to be binding and inure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complication (burns, fractures, disc injuries, strokes, dislocations, sprains, increase or worsening of symptoms) arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Signature: _____Date: _____

PATIENT HEALTH INFORMATION CONSENT FORM (HIPPA)

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature_____ Date_____.