

Chiropractic Case History/Patient Information

Date: _____

Name _____ Social Security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

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

Age _____ Birth Date _____ Race _____ Marital: M S W D How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Employer _____ Phone _____

Emergency Contact _____ Relationship _____ 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? _____

History of Present Illness:

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 _____

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 (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 of any kind? Yes No

If yes, describe: _____

Social History:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? ____ If so, how many packs per day? _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day? _____

Do you exercise? _____ If yes, what is the frequency? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting____ Sitting____ Working at the computer ____

Family History:

Father: living: _____ deceased _____ Current age if still living: _____ Cause of death and age at death if deceased: _____ (check one)

Mother: living: _____ deceased _____ Current age if still living: _____ Cause of death and age at death if deceased: _____ (check one)

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 _____

Please check any and all insurance coverage that may be applicable in this case.

- Major Medical Worker's Compensation Medical Saving Account & Flex Plans
- Medicare Auto Accident 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 patients 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 you 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing _____ Care Date _____

Summary

1. What is your major symptom? _____

2. If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? Yes ____ No ____ Same ____ Better ____ Gradually Worse _____

If yes, when and how? _____

3. How frequent is the condition? Constant ____ Daily ____ Intermittent ____ Night Only _____

How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that may be related to your major symptom?

Yes ____ No _____. If yes, describe _____

Are there other unrelated health problems? Yes ____ No _____. If yes, describe _____

5. Describe the pain: Sharp ____ Dull ____ Numbness ____ Tingling ____ Aching _____

Burning _____ Stabbing _____ Other _____

6. Is there anything you can do to relieve the problem? Yes ____ No _____. If yes, describe _____

_____. If no, what have you tried to do that has not helped? _____

7. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

8. Have you had any broken bones? Yes ____ No _____. If yes, please list and give dates _____

9. List any major accidents you have had other than those that might be mentioned above: _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No _____. If yes, please explain _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes ____ No ____ Uncertain _____

12. Remarks: _____

13. NO SYMPTOMS

EXTREME SYMPTOMS

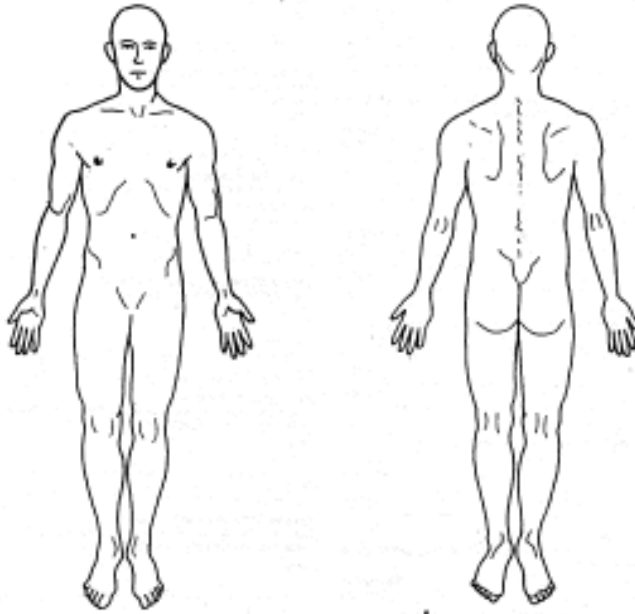
Please place an "X" on the line above to indicate your level of problem.

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>> Numbness ===== Pins & Needles o o o o
Burning x x x x Stabbing // // // Throbbing ~ ~ ~ ~ ~



INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, nonduplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at ACE Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____

Date: _____

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare _____ Medicaid _____ Group Health Plan _____ Other _____
2. Insured's ID Number _____
3. Patient Name: _____
4. Insured Name: _____
5. Insured date of birth: _____ SSN: _____ Male _____ Female _____
6. Insured employer name or School name: _____
City _____ State _____ Zip _____ Tel # _____
7. Insured's Address (if same as patient put "same"): _____
City _____ State _____ Zip _____ Tel # _____
8. Patient Status (circle one): *Single Married Other Employed Full-time Student Part-time Student*
9. Is the condition we are treating related to current or previous employment? Yes ___ No ___
10. Is the condition we are treating related to an auto accident? Yes No ___
11. Is the condition we are treating related to another type of accident? Yes No ___
12. Is there another health benefit plan? Yes No ___ If yes, list: _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____ Date: _____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes ___ No ___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes ___ No ___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes ___ No ___
4. Is this illness or injury the result of an accident or other injury? Yes ___ No ___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes ___ No ___
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes ___ No ___
7. Do you have a Medicare Medigap Policy? Yes ___ No ___ Name of Company _____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes ___ No ___