# INTRODUCTION PATIENT CASE HISTORY

**Today's Date:** ____/____/_____

## PATIENT INFORMATION

**Name:** *(First MI Last)* _____ **Preferred Name**: _____

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

**Date of Birth:** _____ **Gender:** ☐ Male ☐ Female **Social Security #**:_____

**Home:** _____ **Mobile:** _____ **Work:** _____

**Email:** _____

**Preferred Method of Contact**: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: _____

***Referred By:** *(Name)* _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

**Race & Ethnicity:** *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

**Preferred Language:**

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

## EMERGENCY CONTACT INFORMATION

**Name:** *(First MI Last)* _____ **Primary Care Physician:** _____

**Home:** _____ **Mobile:** _____ **Doctor's Phone:** _____

**Relationship**:

☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

## FINANCIAL INFORMATION

**Is today's visit the result of an accident?**

☐ No ☐ Auto ☐ Work ☐ Other: _____

**Will we be working with insurance?** ☐ No ☐ Yes *(Details)*

*Primary:* _____ *ID#:* _____

*Secondary:* _____ *ID#:* _____

**Where would you like statements sent?**

☐ Self ☐ Other *(Details below)*

*Name:* _____

*Address:* _____

*Phone:* _____ *Email:* _____

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

**Account No:** _____

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

**Major Complaint:** _____ **Secondary Complaints:** _____

_____ _____

_____ _____

**When did it start?** ____/____/_____ **What happened?** _____

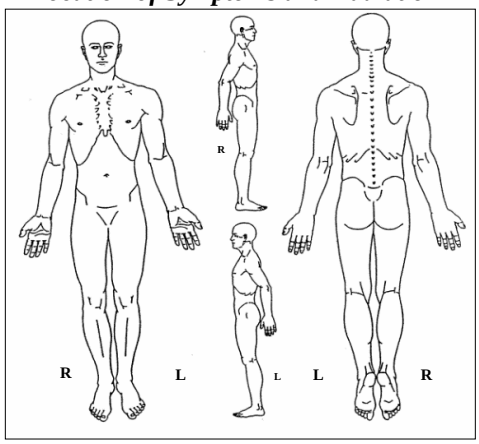
_____

**Which daily activities are being affected by this condition?** _____

_____

## MAJOR COMPLAINT

***Location of Symptoms and Radiation***




P __ Pain T__ Tender
N __ Numb H__ Hypoesthesia
S __ Spasm

**Grade Intensity/Severity:**

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

**Frequency:**

- ☐ Off & On
- ☐ Constant

**Quality:**

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

**Does it radiate?**

☐ No ☐ Yes *(Please indicate on drawing)*

**Improves with:**

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

**Worsens with:**

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

**Previous Treatment:**

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

**Previous Diagnostic Testing:**

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

***Women:** ***Are you pregnant?***

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

*Present Illness Comments:*

_____

_____

_____

_____

_____

_____

**Prescription Medications & Supplements:** ☐ None

☐ Yes *(List – Name, dosage, frequency)* _____

_____

_____

_____

_____

_____

**Allergies to Medications:** ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*_____

_____

_____

_____

_____

_____

# PAST, FAMILY, AND SOCIAL HISTORY

## PAST MEDICAL HISTORY

**Have you *ever* had any of the following?** *(Please select all that apply and use comments to elaborate.)*

**Illnesses:**

- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) _____
- ☐ Blood Clots
- ☐ Cancer (*Type*) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

**Injuries:**

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

**Hospitalizations:** *(Non-surgical with Date)*

_____

_____

**Surgeries:** *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - Shoulder – R / L _____
  - Elbow/Forearm – R / L _____
  - Wrist/Hand – R / L _____
  - Hip – R / L _____
  - Knee – R / L _____
  - Ankle/Foot – R / L _____
- ☐ Spinal Surgery
  - Neck: _____
  - Back: _____
- ☐ Other: _____

_____

_____

*Medical History Comments:*

_____

## FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

| | Mother | Father | Sibling1 | Sibling2 | Sibling3 | Child1 | Child2 | Child3 |
|---|---|---|---|---|---|---|---|---|
| Gender | F | M | | | | | | |
| Age at death *(if Deceased)* | | | | | | | | |
| Aneurysms | | | | | | | | |
| CVA (Stroke) | | | | | | | | |
| Cancer | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Disease | | | | | | | | |
| Hypertension | | | | | | | | |
| Other Family History | | | | | | | | |

*Family History Comments:*

_____

## SOCIAL AND OCCUPATIONAL HISTORY

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Other

**Children:** ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:_____

**Student Status:** ☐ Full Student ☐ Part Student ☐ Non-Student

**Highest level of Education:** ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: _____

**Employed:** ☐ No ☐ Yes (*Occupation*) _____

**Dominant Hand:** ☐ Right ☐ Left ☐ Ambidextrous

**Smoking/Tobacco Use:** *If current smoker, amount =* _____

☐ Every Day ☐ Some Days ☐ Former ☐ Never

**Alcohol Use:**

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

**Caffeine Use:**

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

**Exercise frequency:**

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

*Social History Comments:* _____

_____

# REVIEW OF SYSTEMS



***Many of the following conditions respond to chiropractic treatment.***

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

**Constitutional:** *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: _____
- ☐ *None in this Category*

**Musculoskeletal:**
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

**Neurological:**
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

**Psychiatric:** *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

**Genitourinary:**
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

**Gastrointestinal:**
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

**Cardiovascular & Heart:**
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: _____
- ☐ *None in this Category*

**Respiratory:**
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _____
- ☐ *None in this Category*

**Eyes & Vision:**
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: _____
- ☐ *None in this Category*

**Head, Ears, Nose, & Mouth/Throat:**
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____
- ☐ *None in this Category*

**Endocrine:**
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: _____
- ☐ *None in this Category*

**Hematologic & Lymphatic:**
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: _____
- ☐ *None in this Category*

**Integumentary:** *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: _____
- ☐ *None in this Category*

**Allergic/Immunologic:**
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

*Review of Systems Comments:*

_____

*I have answered these questions to the best of my knowledge and certify them to be true and correct.*

Patient 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 |





INNATE INTELLIGENCE WITHIN
Revision Date 06/01/2020

# ***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 chiropractic 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 |



Revision Date 06/01/2020