Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

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

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____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:

Chief Complaint: 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

Do you have a history of stroke or hypertension?_____

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 to any medications? □ Yes □ No

If yes, describe:_____

Do you have any 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?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, 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 and type of exercise?_____
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_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents:
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)

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

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 □ Medicaid □ Medicare □ Auto Accident
□ Medical Savings Account & Flex Plans □ 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 patient 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 your 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:_____

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

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received 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.

The undersign 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.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Informed Consent Document

PATIENT NAME_____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" Much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment May involve some or all procedures listed below

___spinal manipulation therapy___ palpation ___ vital signs

___range of motion testing ___ orthopedic testing___ basic neurological testing ___ muscle strength testing___ ultrasound Postural analysis testing___ hot/cold therapy___ EMS___

Radiographic studies___ traction___ nutritional products___

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 patients will feel some stiffness and soreness following the first few days of treatment. The doctor 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 the doctors attention it is your responsibility to inform the doctor.

The probability if those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check during the taking of your history and examination and X-RAY. Stroke and/ or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

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 pain-killers.

*Hospitalization *Surgery

If you choose 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.

The 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. PLEASE CHECK THE APPROPRIATE BLOCK 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. Terry Meredith, D.C. 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 treatment recommended. Having been informed of the risks,

I hereby give my consent to that treatment.

DATED_____ **DATED _____**

_____ **_____**

PATIENT’S NAME **DOCTOR’S NAME**

_____ **_____**

PATIENT’S SIGNATURE

SIGNATURE OF PARENT OR GUARDIAN (IF MINOR)

Neck Pain (only)

Today's Date: _____

How severe is the pain?

(None) (Severe)

|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|

1 5 10

How often do you feel pain?

(None) (Consistent)

|---------|---------|---------|---------|

0% 25% 50% 75% 100%

Type of pain? Sharp Stabbing Deep Dull Achy Numb Tingling

Does the pain radiate to the arms or hands? _____

Do you have any weakness in your arms or hands? _____

Do you have trouble dropping things? _____

Do you experience headaches? _____ How often? _____

Type of headaches? Sharp Stabbing Squeezing Throbbing Other_____

With your headaches, do you experience any of the following:

Nausea, vomiting, jaw or face pain, ringing of the ears, dizziness, loss of balance, blurring vision, grinding or clicking when you turn your head? (Please circle all that apply)

Does coughing or sneezing cause pain? _____where? _____

What makes the problem worse? _____

What can you do to relieve the problem? _____

Middle Back, Between Shoulder Blades, Around Ribs (only)

Today's Date: _____

How severe is the pain?

(None) (Severe)

|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|

1 5 10

How often do you feel pain?

(None) (Consistent)

|---------------|---------------|---------------|---------------|

0% 25% 50% 75% 100%

Type of pain? Sharp Stabbing Deep Dull Achy Numb Tingling

Does the pain radiate around ribs or chest? _____

Do you experience frequent heartburn or indigestion? _____

Does coughing or sneezing cause pain? _____ Where? _____

What makes the problem worse? _____

What can you do to relieve the problem? _____

Hands, Elbows, Knees, Feet (only)

Please explain in detail the major complaint of the above circled.

_____

_____

How often do you feel pain?

(None) (Severe)

|---------------|---------------|---------------|---------------|

0% 25% 50% 75% 100%

Type of pain? Sharp Stabbing Deep Dull Achy Numb Tingling

Low Back Pain (only)

Today's Date: _____

How severe is the pain?

(None) (Severe)

|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|

1 5 10

How often do you feel pain?

(None) (Consistent)

|---------------|---------------|---------------|---------------|

0% 25% 50% 75% 100%

Type of pain? Sharp Stabbing Deep Dull Achy Numb Tingling

Does the pain radiate into legs and feet? _____

Do you have any weakness in your legs? Right_____ Left_____ Both_____

Do your legs ever give out on you? Right_____ Left_____ Both_____

Do you ever experience the following:

Constipation, diarrhea, pain when using the restroom, change of color in stool, difficulty or frequent urination, burning or change of color in urine, change in menstrual cycle, or pain during intercourse.

Does coughing or sneezing cause pain? _____ Where? _____

What makes the problem worse? _____

What can you do to relieve the problem? _____

What type of bed do you sleep in? Regular_____ Waterbed_____

For X-Ray purposes, are you pregnant? _____

Patient/ or Guardian Signature_____ Date _____