

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? _____

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. The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____ Date: _____

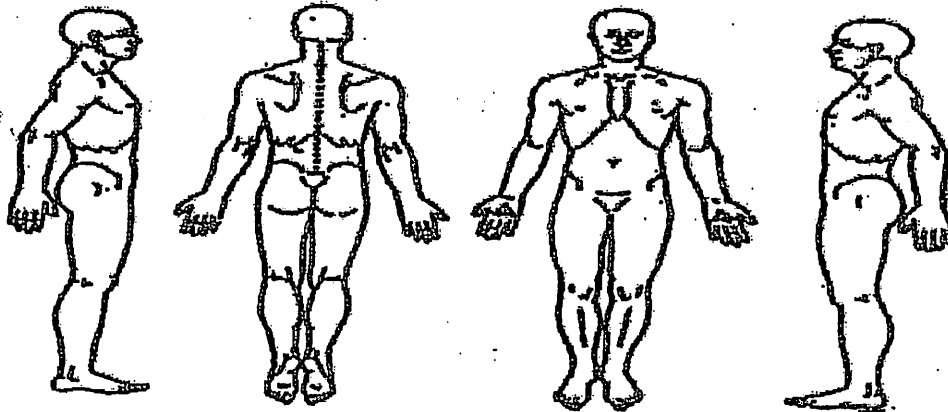
Guardian's Signature Authorizing Care: _____ Date: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem? What Make is better?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Other: _____		

- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Tobacco Use
- Drug/Alcohol Dependence
- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

For Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes
if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

28. List all Vitamins or supplements you currently take: _____

Patient Signature _____ Date: _____

PATIENT HEALTH INFORMATION CONSENT FORM

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 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 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/her own health records at any time and request correction. The patient may request to know what disclosures have been made and submit in writing any further restriction on the use of their PHY. 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 effect 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 know by this office to assure that your records are not readily available to those who do not need the.
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 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.

NAME OF PATIENT

DATE

EHR Certification – Patient Information

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: (To be entered in EZnotes through "Edit Patient Info")

Name: (Print clearly) _____ Today's Date: _____

Date of Birth: _____

Ethnicity: (Please circle)

Race: (Please circle)

Hispanic or Latino	Not Hispanic or Latino
--------------------	------------------------

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	Two or more

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other _____

What is your preferred method of contact?

Phone Number: _____

Home	Work	Cell
------	------	------

Phone Call: Text Message:

E-Mail: _____

Mailing Address: _____

OFFICE USE ONLY

Vitals: In EZnotes, complete by:

- 1) Going to "Exain" screen
- 2) "Select by region"
- 3) Then select "Vitals"

Blood Pressure: _____ / _____ Height: _____ Weight: _____

Smoking Status: Smokes every day Smokes some days Former Smoker Never Smoked

PRESCRIBED MEDICINES

Check here if not taking any medications:

Medication: i.e. Lipitor	# of MD refills issued:	Quantity of Pills:	Strength: i.e. 10 mg	Dose Form: i.e. Capsule	MD's instruction: i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line:

Check here if you do not have any medical allergies:

Name of Drug: i.e. penicillin	Symptom: i.e. headache

Have you been diagnosed with either of the following: (Please circle:)

Asthma? Diabetes?

I would like to electronically have access to my health information: (Please initial box)

OFFICE USE ONLY

Timely access: In EZnotes, complete by

- 1) Going to "Edit Patient" section for this patient
- 3) Select "Asked Timely Access"

Completed?

Medications: In EZnotes, complete by

- 1) Going to "Edit Patient"
- 2) "Edit /View Patient's Data"
- 3) "Prescriptions/Allergies"

Completed?

Entered into EZnotes by (name): _____ Date & Time: _____