# Confidential Case History

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

Name:_____ Home #: _____

Address:_____ City:_____ State:_____Zip:_____

E-mail address: _____ Cell # and provider:_____

Contact Preference: Email Cell Home Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Number of children? _____Names and Ages of Children:_____

_____

Emergency Contact:_____ 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? ☐ Yes ☐ No

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 NAME** _____ **DATE** _____

**PRESENT HISTORY**

Chief Complaint/Purpose of this appointment:_____

Date symptom(s) appeared or accident happened:_____

How did the symptom(s) start? _____

Is this condition getting progressively worse? ☐ Yes ☐No ☐Unknown

Pain level (0=none, 10=severe) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Type of pain: ☐Achy ☐Burning ☐Dull ☐Sharp ☐Stiff ☐Throbbing ☐Numbness ☐Tingling ☐Other _____

Is the pain: ☐None ☐Occasional ☐Intermittent ☐Frequent ☐Constant

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other _____

Activities or movements that make the pain worse/aggravate the pain: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lifting ☐Coughing ☐Lying Down ☐Other _____

Activities or movements that make the pain better/relive the pain: ☐Sitting ☐Standing ☐Lying Down ☐Movement ☐Heat ☐Ice ☐Medication ☐Stretching ☐Other _____

Have you ever had the same or a similar condition in the past? ☐ Yes ☐No - If yes, when and describe:_____

_____

Do you have any other complaints/symptoms? ☐ Yes ☐No - If yes, describe:_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries (list below)? 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, drugs, vitamins, mineral, or herbal supplements are you taking?_____

_____

Do you have any allergies of any kind? ☐ Yes ☐ No If yes, describe:_____

Do you have any Congenital Conditions? ☐ Yes ☐ No If yes, describe_____

**Women:** Are you pregnant or is there any chance that you may be? ☐ Yes ☐ No

Please indicate which activities of daily living are affected by your current state of health:

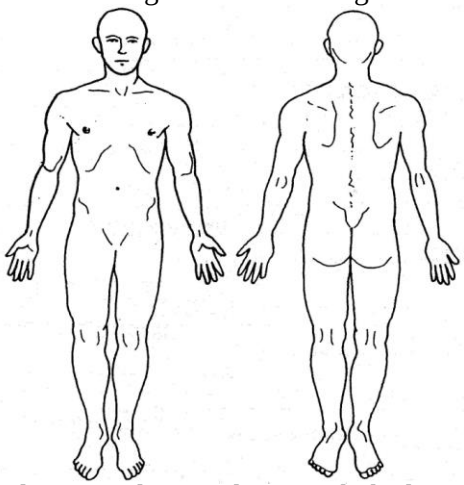
| | | | | |
|---|---|---|---|---|
| **General:** | ☐Walking | ☐Sitting | ☐Climbing stairs | ☐Chewing |
| | ☐Kneeling | ☐Sleeping | ☐Standing | ☐Lifting children |
| | ☐Reading | ☐Swimming | ☐Playing instrument | ☐Using telephone |
| | ☐Running | ☐Bending | ☐Lying in bed | ☐Using keyboard |
| | ☐Exercising | ☐Sitting in recliner | ☐Sports | ☐Sewing or crafts |
| | ☐Getting into/out of an automobile | | ☐Recreational Activities | ☐Other _____ |
| **Housework:** | ☐Doing laundry | ☐ Making beds | ☐Vacuuming | ☐Washing dishes |
| | ☐Ironing | ☐Carrying groceries | ☐Caring for pets | ☐Cooking |
| **Yard work:** | ☐Mowing lawn | ☐Raking leaves | ☐Gardening | ☐Shoveling |
| **Grooming:** | ☐Combing hair | ☐Shaving | ☐Getting in/out of bathtub | ☐Brushing teeth |
| **Travel:** | ☐Driving a car | ☐Riding in a car | | |

**PATIENT NAME** _____ **DATE** _____

**CONDITION INFORMATION**

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

A = Ache N = Numbness P = Pins & Needles B = Burning S = Stabbing T = Throbbing D=Dull



**SOCIAL HISTORY**

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Exercise _____ Alcohol Use

_____Tobacco Use _____ Caffeine Use

**REVIEW OF SYSTEMS**

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now**, **P** if you have had these conditions **previously**, or **N**/A if you have never had these conditions. Please fill in all blanks.

**N = Now** **P = Previously** **N/A = Not Applicable**

| | | | |
|---|---|---|---|
| Headaches | _____ | Dizziness | _____ |
| Loss of Balance | _____ | Neck Pain or stiffness | _____ |
| Fainting | _____ | Loss of Taste | _____ |
| Loss of Smell | _____ | Joint Pain/Swelling | _____ |
| Back Pain | _____ | Sleeping Problems | _____ |
| Unusual Bowel Patterns | _____ | Difficulty Urinating | _____ |
| Nervousness | _____ | Weakness in Extremities | _____ |
| Feet Cold | _____ | Hands Cold | _____ |
| Numbness in Toes | _____ | Numbness in Fingers | _____ |
| Irritability | _____ | Arthritis | _____ |
| Chest Pains/Tightness | _____ | Rheumatoid Arthritis | _____ |
| Shoulder/Neck/Arm Pain | _____ | Fatigue | _____ |
| Muscle Spasms | _____ | Tension | _____ |
| Fever | _____ | Sinus Problems | _____ |
| Diabetes | _____ | Gall Bladder Problems | _____ |
| Ulcers | _____ | Indigestion Problems | _____ |
| High Blood Pressure | _____ | Low Blood Pressure | _____ |
| Menstrual Difficulties | _____ | Osteoporosis | _____ |
| Breathing Problems | _____ | Weight Loss/Gain | _____ |
| Lights Bother Eyes | _____ | Loss of Memory | _____ |
| Ears Ring or Buzzing | _____ | Coughing Blood | _____ |
| Broken Bones/Fractures | _____ | Circulation Problems | _____ |
| Seizures/Epilepsy | _____ | Pacemaker | _____ |
| Heart Disease | _____ | Stroke | _____ |
| Cancer | _____ | Other | _____ |

How often does your job involve lifting? ☐Never ☐Occasionally ☐Frequently ☐Constantly

Other job requirements (please check all that apply): ☐Bending ☐Carrying ☐Stooping ☐Twisting ☐Turning ☐Walking ☐Other:_____

What is your primary work position? ☐Seated ☐Standing ☐Other:_____

**PATIENT NAME** _____ **DATE** _____

**FAMILY HISTORY**

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

| CONDITION | FATHER Age [ ] | MOTHER Age [ ] | SPOUSE Age [ ] | BROTHER(S) Age [ ] Age [ ] | SISTERS Age [ ] Age [ ] | CHILDREN Age [ ] Age [ ] |
|---|---|---|---|---|---|---|
| Arthritis | | | | | | |
| Asthma-Hay Fever | | | | | | |
| Back Trouble | | | | | | |
| Bursitis | | | | | | |
| Cancer | | | | | | |
| Constipation | | | | | | |
| Diabetes | | | | | | |
| Disc Problem | | | | | | |
| Emphysema | | | | | | |
| Epilepsy | | | | | | |
| Headaches | | | | | | |
| Heart Trouble | | | | | | |
| High Blood Pressure | | | | | | |
| Insomnia | | | | | | |
| Kidney Trouble | | | | | | |
| Liver Trouble | | | | | | |
| Migraine | | | | | | |
| Nervousness | | | | | | |
| Neuritis | | | | | | |
| Neuralgia | | | | | | |
| Pinched Nerve | | | | | | |
| Scoliosis | | | | | | |
| Other: | | | | | | |

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

# INFORMED CONSENT

PATIENT NAME _____

Clinic Name – Pure Chiropractic _____

Doctor's Name – Jerry Pokorney, D.C. _____

Address – 3105 Rock Hill Church Road, Suite 101, Concord, NC 28027 _____

Phone – (704) 793-1329 Fax – (704) 793-1392 _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

# 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 undersigned 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)