Iowa Chiropractic Clinic, P.C.
Case History
Please complete the questionnaire. Your answers will help determine how we can help you best. (Please Print)

Date : _____/_____/_____

Name: _____ MI _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Patient SS# _____ - _____ - _____

Male _____ Female _____ Martial Status: S M W

Birth Date: _____/_____/_____

Occupation: _____

Employer: _____

Work Phone: _____

Insured's Name: _____

Insured's Address: _____

_____

Insured's Birth Date: _____/_____/_____

Insured's Employer: _____

Insured's Work Phone: _____

Referred by: _____

Physician: _____

Address: _____

May we contact your physician? Yes _____ No _____

Describe present complaints and symptoms: _____

_____

_____

Current Medications: _____

_____

How would you describe the pain (Circle one below)?

Constant Intermittent Local Radiating

Rate the intensity of pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

What makes the pain better?

_____

What make the pain worse?

_____

Date you first noticed symptoms

_____/_____/_____

Is this condition due to an accident? Yes ____ No ____

If so, what type? Auto Work Home Other

Has this happened before? Yes _____ No _____

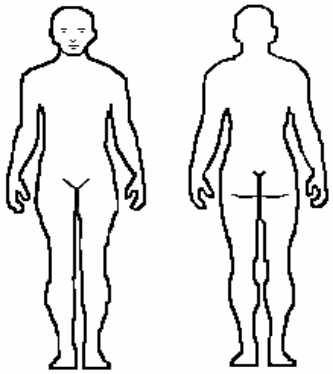
If so, when? _____

Pain Diagram:

____Sharp ^^^ ____Dull = = =

____Stabbing //// ____Burning xxx

____Tingling ooo ____Other +++



Have you ever:

Been knocked unconscious? Yes ____ No ____

Used a crutch or other support? Yes ____ No ____

Been treated for spine/nerve disease? Yes ____No ____

Had a fractured bone? Yes ____ No ____

Had surgery? Yes ____ No ____

Had any other hospitalizations? Yes ____ No ____

Had any mental/emotional disorders? Yes ____ No ____

Been in an auto accident? (Circle 1 below if applicable)

Never Past year Past 5 years Over 5 years

Had a personal injury? (Circle one below if applicable)

Never Past year Past 5 years Over 5 years

Please check the appropriate box for any of the following symptoms you have or have been diagnosed with in the past. We would like to have a thorough understanding of your health before we begin treatment. This is a confidential health report, please complete all fields to the best of your knowledge.

Pain or numbness in:

___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___ Swollen Joints

Muscle & Joint

___ Arthritis
___ Bursitis
___ Foot Trouble
___ Low Back Pain
___ Pain Between Shoulders

For Women Only:

___ Congested Breasts
___ Cramps or Backache
___ Excessive Menstrual Flow
___ Hot Flashes
___ Irregular Cycle
___ Lumps in Breasts
___ Menopausal Symptoms
___ Miscarriage
___ Painful Menstruation

Conditions

___ Alcoholism
___ Anemia
___ Appendicitis
___ Cancer
___ Diabetes
___ Eczema
___ Emphysema
___ Goiter
___ Gout
___ Heart Disease
___ Multiple Sclerosis
___ Polio
___ Rheumatic Fever
___ Stroke
___ Tuberculosis
___ Ulcers

Genito-Urinary

___ Bed Wetting
___ Blood In Urine
___ Frequent Urination
___ Kidney Infection
___ Kidney Stones
___ Painful Urination

Respiratory

___ Chest Pain
___ Chronic Cough
___ Difficult Breathing
___ Spitting Up Blood
___ Spitting Up Phlegm
___ Wheezing

Gastro-Intestinal

___ Colon Trouble
___ Gall Bladder
___ Hemorrhoids
___ Liver Trouble
___ Pain Over Stomach

Cardiovascular

___ Hardening of Arteries
___ High Blood Pressure
___ Low Blood Pressure
___ Pain Over Heart
___ Poor Circulation
___ Rapid Heart Beat
___ Slow Heart Beat

General

___ Allergy
___ Convulsion
___ Dizziness
___ Fainting
___ Headache
___ Numbness

ENT

___ Asthma
___ Earaches
___ Ear Noises
___ Eye Pain
___ Sore Throat
___ Nose Bleed
___ Sinus Infection

Please answer the following questions to the best of you ability:

Date of Last:

Spinal Exam: _____
Physical Exam: _____
X-rays: _____
Lab Test: _____

Do you use:

Alcohol: Yes No
Coffee: Yes No
Tobacco: Yes No
Exercise: Yes No
Medications: Yes No

To the best of my knowledge, all information I have given is accurate, and I have read the case history questions entirely.

Signature: _____ **Date:** _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Iowa Chiropractic Clinic, PC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

INFORMED CONSENT:

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 adjustment 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 care if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she 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, non-duplicating 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 regimen. I understand that if I am accepted as a patient Iowa Chiropractic Clinic, PC, 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.

_____ _____

Signature of Insured / Guardian Date

Acknowledgement:

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

_____ _____

Signature of Insured / Guardian Date

Office Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance**: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductions and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance my not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do accept secondary assignment and will file any unpaid services to your secondary insurance. The balance remaining after filing to both parties is complete will be considered your responsibility.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within 90 days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your frequency of care is once per month or less, there is a possibility that your insurance company will not cover your treatment. If this occurs, you will be considered a cash patient and follow the terms for not having insurance. If there is an exacerbation of your condition and/or your frequency increases, please notify the front desk of these changes. We may then try to file those charges to your insurance company for potential reimbursement.

If you discontinue care for any reason other than discharge by the doctor, all balances become immediately due and payable in full by you, regardless of any claim submitted.

For your convenience you may retain your credit card number on file with us.

Card #: _____ Expiration Date: _____

Name as appears on card: _____

(Office Policy Continued)

Women Only:

To the best of my knowledge **(I am/ am NOT pregnant)** and **(give my permission / don't give my permission)** to x-ray me for diagnostic interpretation. (Please Circle One) (Please Circle One)

Missed Appointments:

There is a possible $25 fee charged for all appointments that are not cancelled prior to a scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications

In the event that we should need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails?

_____ Yes

_____ No

Acknowledgement:

Patient's Printed Name: _____

Signature: _____Date: _____

Office Manager: _____Date: _____