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
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive Bleeding
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pace Maker
__Strokes
__Cancer
__Ruptures
__Coughing Blood
__Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression
__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____
Diabetes ____
Stroke ____
Arthritis_____
Other ____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____

Mental Illness____
Heart Disease ____
Lung Disease____

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:________________

SUMMARY

1. What is your major symptom? ____

2. What does this prevent you from doing or enjoying?________________________________

3. If this is a recurrence, when was the first time you noticed this problem?__________________

   How did it originally occur?____

   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

   If yes, when and how? ____

4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

   How long does it last? All Day _________ Few Hours ___________ Minutes ______________

5. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____. If yes, describe: ______________________________________

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe __________

   ____

6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other ____

7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _______

   ____________________. If no, what have you tried to do that has not helped? ______________

   ____

8. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____

   Lifting _____ Twisting _____ Other ____

9. List any major accidents you have had other than those that might be mentioned above: _______

   ____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

11. Remarks: ____

    ____

    ____

NO SYMPTOMS |____| EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature ____ Date _____________

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare____Medicaid____Champus___CampVA____
   Group Health Plan____ Other____Insured's ID Number______
2. Patient Name:____
3. Insured's Name (as it appears on the insurance card):______________________
4. Patient's Address:____
   City________________________State_______ Zip________Tel #____________________
5. Insured's Address (if same as patient put "same"):____
   City___________________State_______ Zip________Tel #__________________________
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):____
   Other Insured's Policy or Group Number:____
   Other Insured's Date of Birth:___________________ Male________Female_______
   Employer's Name or School Name:_______________________________________
   Insurance Plan Name or Program Name:_________________________________
8. Is the condition we are treating related to current or previous employment? Yes____ No____
9. Is the condition we are treating related to an auto accident? Yes____ No____
10. Is the condition we are treating related to another type of accident? Yes ____ No____
11. Insured's Policy Group or FECA Number:______________________________________
    Insured's Date of Birth:______________________Male_______Female_______
    Employer Name or School Name:____________________________________
    Insurance Plan Name or Program Name:______________________________
12. Is there another health benefit plan? Yes____ No____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: ____Date:_______________

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: ____Date:________________

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___Name of Company_________________________
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___

Insurance Company____________________________________Phone # __________________

Claims Address____Fax #________________

Name and title of person giving information:____

HCFA 1500 form okay? Yes No

What is your deductible? $_____________Deductible remaining? $__________

Is deductible: annual or per incident? (circle one) Date deductible starts:______

Percentage payment:_______________%

Is there a maximum number of visits allowed? Yes No If yes, number:______

Will you pay for therapy? Yes No Maximum # per visit_____ per year?______

Any $ limitations on visits?________________ Therapy?___________________

Will you accept E/M codes (99201-99204) from chiropractors?_______________

Will you accept CMT (Chiropractic Manipulative codes 98940-98943)?_________

Any x-ray limitations?____

Do you require pretreatment authorization? Yes No

Procedure:____

Do you pay for examinations? Yes No

Any re-exam stipulations?____

Do you pay for: Supports Pillows Vitamins/Supplements Orthotics

Any limitations?____

Do you accept and honor assignment of benefits? Yes No

Add'l Notes:____

____

Person taking information:__________________________________Date:________________

Office Use Only
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>5

Patient #:____________________

Pain Drawing

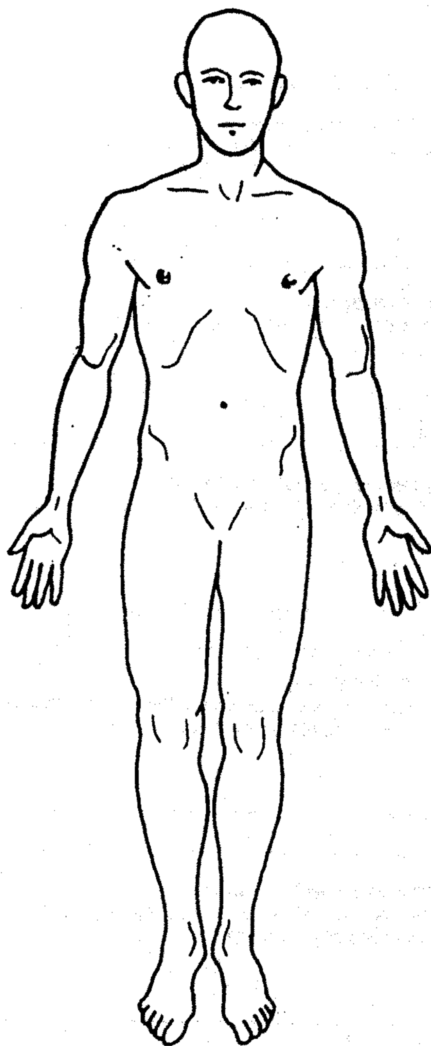
Name:_______________________________________ Date:______________________________

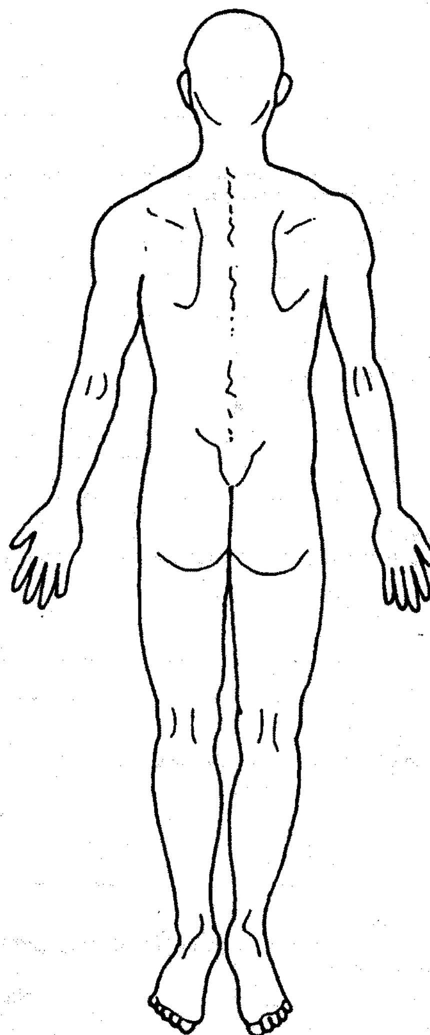
Date of Birth:________________________________ Examiner:__________________________

TELL US WHERE YOU HURT.

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

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~





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 chiropractic 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 chiropractic 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 or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. 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 known by this office to assure that your records are not readily available to those who do not need them.
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 chiropractic 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

____

Signature of Patient   Date