Flexx Chiropractic Case History/Patient Information

Today's Date:_____ Case Number #_____ **CA/Doctor:**_____

Name:_____ Social Security #:_____ Age:_____ Birth Date:_____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Home #_____ Cell #_____

Gender: ☐M ☐F Preferred Contact ☐Home ☐Work ☐Cell Cell Carrier/Company:_____

Do we have permission to contact you occasionally by text message for appointment reminders, etc. ? ☐Y ☐N

Occupation:_____ Employer:_____

Employer's Address:_____ Work Phone:_____Ext:____

Marital Status: ☐M ☐S ☐W ☐D Spouse:_____ Employer:_____

Spouse Employer Address:_____ Spouse Work #:_____

# of children? _____ Names and Ages of Children: _____

_____

Emergency contact: _____ Relationship to emergency contact:_____

Emergency contact number: _____

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? ☐Y ☐N

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 and Date of Birth of Insured/Employee:_____
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:_____

NAME _____ DATE _____ DOCTOR_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint(s)/Purpose of this appointment:_____

_____

_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

The severity of your complaint/concern is: ☐Mild ☐Mild-moderate ☐Moderate ☐Moderate-severe ☐Severe

The frequency of complaint/concern is: ☐Occasional ☐Intermittent ☐Frequent ☐Constant

Describe the pain: ☐Achy ☐Burning ☐Dull ☐Sharp ☐Shooting ☐Stabbing ☐Throbbing ☐Other____

On a scale of 0 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None=0 1 2 3 4 5 6 7 8 9 10=Worst possible

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

_____

Date of last physical examination:_____Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries (give dates and descriptions):_____

_____

_____

_____

_____

Have you been treated for this or any other health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:_____

What medications, drugs, or supplements are you taking (remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control, blood pressure, etc.)?_____

_____

_____

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:_____

Do you have any congenital conditions? ☐ Yes ☐ No If YES, describe:_____

Women: Are you pregnant? ☐ Yes ☐ No

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

_____Exercise	_____Family Pressures	_____Financial Pressures
_____Alcohol Use	_____Other Mental Stresses	_____Caffeine
_____High Stress Activities	_____Tobacco Use	Other (specify) _____
		_____

NAME _____ DATE _____ DOCTOR_____

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**, and **N/A** if the condition is **not applicable** to you.

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

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

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

Housework: ☐Doing laundry ☐Making beds ☐Vacuuming ☐Washing dishes
☐Ironing ☐Carrying groceries ☐Caring for pets ☐Cooking

Yardwork: ☐Mowing lawn ☐Raking leaves ☐Gardening ☐Shoveling

Grooming: ☐Combing hair ☐Shaving ☐In/out of bathtub ☐Brushing teeth

Travel: ☐Driving a car ☐Riding in a car ☐_____ ☐_____

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:

NAME _____ DATE _____ DOCTOR_____

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						
Sinus Trouble						
Stomach Trouble						
Other:						

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

_____

_____

_____

Have you seen a chiropractor before? ☐Y ☐N – if Yes, whom?_____

For what condition?_____ When was your last adjustment? _____

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Flexx Chiropractic
111 Alabama St.
Columbus MS, 39702
(662) 327-6586

Patient Name: _____ Patient #:_____

PAYMENT POLICY INFORMATION

Payment for Services will be by: Cash_____ Check_____ Credit Card _____

Chiropractic Services provided in this office are payable the day services are rendered unless other arrangements have been made prior to seeing the doctor.

1. Patients are personally responsible for all charges. If the staff is unable to verify insurance benefits prior to the end of your first visit, payment is due in full.
2. There will be a $5.00 charge for paperwork above and beyond the normal claims information needed to process group or individual insurances or if more than 2 (two) insurances are involved.
3. Payment Plan is available upon approval of credit extension by the Office Manager. I authorize a credit check if credit is extended.
4. Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office. There will be verification of coverage; however "**benefits quoted are not a guarantee of payment."** Benefits are determined at the time of processing.
5. Any balance remaining after 60 days with no action on the account will be charged an 18% per annual service charge.
6. A collection fee equal to 40% of balance will be added to all delinquent accounts over 90 days past due that have been sent to a collection agency.
7. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports at no charge to assist in collecting from my insurance company.
8. If mine is a regular insurance case, I agree to pay a percentage of services as they are rendered. 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.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY:

PATIENT'S SIGNATURE: X_____ Date: _____
(OR GUARDIAN/GUARANTOR)

Witness's Signature: _____ Date:_____

Flexx Chiropractic
111 Alabama Street
Columbus, MS 39702
662-327-6586

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 Noti**c**e 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)