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 How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of Nearest Relative _____ Address _____ Phone _____

How were you referred to our office? _____

Family Medical Doctor _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

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

_____

Days lost from work _____

Date of last physical examination _____ What surgeries have you had? (Include dates) _____

_____

Serious illnesses (include dates) _____

_____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe: _____

_____

What medications or drugs are you taking? _____

_____

Please check any and all insurance coverage that may be applicable in this case.

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident π 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

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 _____

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. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____

_____

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

_____

11. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____

_____

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

Yes _____ No _____ Uncertain _____

13. Remarks: _____

_____

_____

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

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

Doctor's Signature _____ Date _____

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

AUTHORIZATION AND ASSIGNMENT

TO GEORGE G. JUNKIN D.C.
In consideration of your undertaking to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

ASSIGNMENT OF CAUSE OF ACTION

In the event any insurance company is obligated by contractual agreement to make payment to me or to you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the names(s) of which is/are believed to be correctly set forth under pertinent date below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I personally owe you, and agree to pay in a current manner.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

TO_____
(Name of Attorney and / or Insurance Company)
In consideration of the chiropractic services rendered and to be rendered by him. I authorize and direct the payments to the doctor named above of any sum I now or hereafter owe him by you, my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to reimburse me for the charges for his services or otherwise obligated to make payment to me or him based in whole or in part upon the charges made for his services. If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o_____
_____
_____

ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) health care services at the and that I have been advised that the doctor providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.
I understand that if it is determined either:

(a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection the interest of the doctor; or
(b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney;

Then payment for services rendered by the doctor(s) at the **Northwest Chiropractic Center** will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.
Dated the _____ day of _____ 2008

_____
Patient's Signature

_____
Witness