INTRODUCTION PATIENT CASE HISTORY

Today's Date: ______________

PATIENT INFORMATION

Name: (Last, First MI)________________________________ **Preferred Name:** ________________

Address: ____________________________ **City:** ________________ **State:** _______ **Zip:** __________

Home: ______________ **Mobile:** ______________ **Mobile Carrier:** ______________ **Work:** ______________

Email: ____________________________ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #:____________________________ **Date of Birth:** ____________________________

Student Status: Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** ________________

***Referred By:** ____________________________

Ethnicity: Hispanic or Latino / Other **Preferred Language:** ____________________________

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ____________________________ **Primary Care Physician:** ____________________________

Home: ______________ **Mobile:** ______________ **Doctor's Phone:** ____________________________

Relationship: Child / Parent / Spouse / Other: ____________

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):_________

PRIMARY INSURANCE

Name: ____________________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ____________________ **Gender:** M / F

Address: ____________________________

City: ________________ **State:** _____ **Zip:** ________

Phone: ________________ **Date of Birth:** ___________

SECONDARY INSURANCE

Name: ____________________________

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name: ____________________ **Gender:** M / F

Address: ____________________________

City: ________________ **State:** _____ **Zip:** ________

Phone: ________________ **Date of Birth:** ___________

Who is responsible for payment? Self / Other - *(Relationship)* ________________________

Other than Self:
Full Name: ____________________________ **Phone:** ________________

Address: ____________________________ **City:** ________________ **State:** _______ **Zip:** __________

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: __________

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ______________________________

Began When? ____/_____/______ **Describe how this began:** ______________________________

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: ______________

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? **No / Yes** *(Describe)* ______________

<u>*Head*</u> - Base of Skull / Forehead / Sides-Temple R / L / Both <u>*Leg*</u> - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

<u>*Arm*</u> – Across Shoulder / Elbow / Hand-Fingers R / L / Both <u>*Other Area:*</u> ______________

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ______________

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ______________

Which daily activities are being affected by this condition? *(Describe)* ______________

<u>**For this CURRENT condition, have you:**</u>

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: ______________ **Where?** ______________
- **Had any previous Surgery or Interventions in this area?** *(Describe)* ______________
- **Taken any Medications?** OTC / Prescriptions ______________
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: ______________ **When and Where?** ______________

Describe any Secondary Complaints: ______________________________

HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

<u>*Medications:*</u>

Allergies to Medications: *NONE* *(List)* ______________

____

Current Medications: *NONE*
(Already have a list? We can make a copy.) ______________

____

____

____

____

<u>*Past Health History:*</u> *(Please list any past…)*

Surgeries – Date, Type, and Reason: *NONE*

____

____

____

____

Major Injuries/Traumas: *NONE* ______________

____

____

____

Major Hospitalizations: *NONE* ______________

____

____

<u>*Family Health History:*</u> *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

____

____

____

Deaths in immediate family: *(Cause and at what Age?)*

____

____

____

<u>*Social and Occupational History:*</u>

Level of Education Completed: ______________

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

____

____

____

____

Habits:

Cigarettes – *(#/day)* ______________
Alcohol – *(amount/day)* ______________
Coffee/Tea – *(cups/day)* ______________
Rec. Drugs *(List)* ______________

Patient No: __________

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REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems ______________
- ☐ Leg Problems ______________
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones______________
- ☐ Other: ______________
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other: ______________
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ______________
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: ______________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ______________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: ______________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: ______________
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: ______________
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: ______________
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: ______________
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: ______________
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes -** ***Due Date*** ___/___/___
- ☐ **No -** ***Last Menstrual Period*** ___/___/___

- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: ______________
- ☐ *None in this Category*

Pregnancies with Outcome & Date:
____
____
____

Comments: ____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature ______________________________ Date__________

Treating Doctor Signature ______________________________ Date__________

Patient No: __________

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Bradley Chiropractic
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Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information:

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: CHOOSE ONLY ONE

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, ____________________________ (print) acknowledge that I have reviewed the above information and **GIVE MY PERMISSION** to this office to use and disclose my health information in accordance with it.

OR

☐ I, ____________________________ (print) acknowledge that I have reviewed the above information and **DO NOT GIVE MY PERMISSION** to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient Signature: ____ **Date:** ____________________

Assignment of Benefits

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.**

Assignment and Conveyance of Lien Interest:

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to be paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to the Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

Patient Signature: ____ **Date:** ____________________

Informed Consent to Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

Patient Signature: ____ **Date:** ____________________