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: _____

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)* _____

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

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

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)* _____

For this CURRENT condition, have you:

- **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*)

Medications:

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

_____

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

_____

_____

_____

_____

Past Health History: *(Please list any past...)*

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

_____

_____

_____

_____

Major Injuries/Traumas: *NONE* _____

_____

_____

_____

Major Hospitalizations: *NONE* _____

_____

_____

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

List *relevant* major health problems of immediate relatives:

_____

_____

_____

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

_____

_____

_____

Social and Occupational History:

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: _____

REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic 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: _____

Koester Chiropractic Center
Consent, Assignment and Agreement

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 (PHI) we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. I certify that all the information given in the Chiropractic Case History and Information sheet is true and correct to the best of my knowledge. I give my consent to Koester Chiropractic Center to render treatments to myself/my child as deemed necessary by the attending physician. I understand that I have the right to refuse services at any time, and will be informed of any changes in treatment prior to their performance. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

2. I understand that I am fully responsible for the payment of services rendered. I further understand that health and accident insurance policy are an arrangement between myself and the carrier, and that I may be required to pay some or all of the fees charged to my account. I hereby assign benefits to be paid to this provider by my third-party payer (i.e. insurance company, attorney, etc.) My signature below shows agreement that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract of contract between myself and Koester Chiropractic Center.

3. I hereby authorize the release of any and all information contained in my file as is necessary to any insurance company, attorney or adjuster in order to satisfactorily process my claim(s).

4. I give consent to Koester Chiropractic Center to perform x-rays as deemed necessary by the attending physician. I declare that to the best of my knowledge, (I'm not pregnant, my child is not pregnant) nor are there any known complication limitations which would forbid taking x-rays.

5. I understand that it in the event x-rays are taken, that they may be referred to a licensed secondary imaging consultant for a second opinion of further interpretation and give consent for their release. I understand that there will be a fee for this service billed to my insurance company and I assign benefits to be paid directly to the aforementioned consultants by my third party payer.

6. I authorize Koester Chiropractic Center to send me a monthly newsletter, email, text and any other mail as they see pertinent to me.

7. The patient may provide a written request to revoke consent at any time during care. This would not affect 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.

8. If the patient refuses to sign the consent for the purpose of treatment. Payment and health care operations, the chiropractic physician has the right to refuse 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 (print): _____

Patient/Guardian Signature: _____ Date: _____

A. AUTHORIZATION:

I hereby authorize Koester Chiropractic Center to release information regarding my care to:

Name:_____ **Relation**: _____

B. MEDICAL INFORMATION:

I acknowledge and agree that the term medical information may include: notes by Koester Chiropractic Center and other individuals employed by Koester Chiropractic Center, test results, reports, correspondence, x-rays, and other diagnostic testing, as well as, billing and payment information.

C. SPECIFIC INFORMATION RELEASED:

I expressly authorize release of any and all of the following information, if it is part of my medical records, unless otherwise specified in writing; Mental Health Information, Chemical Dependency/Substance Abuse, and Sexually Transmitted Disease.

D. SIGNATURE:

I understand that I may revoke this authorization at any time by Koester Chiropractic Center's receipt of such revocation in writing:

_____ _____

Print Name of Patient **Date of Birth**

_____ _____

Signature of Patient **Date**