Chiropractic Case History/Patient Information

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

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **E-mail address:** _____

Gender: ___Female ___Male **Race:** _____ **Marital Status:** ___Married ___Single ___ Other: _____

Occupation: _____ **Employer:** _____ **Employer's Address:**_____

Spouse: _____ **Occupation:** _____ **Employer:** _____

How many children? ____ **Ages of Children:** _____

Emergency Contact (relationship?): _____ **Phone:** _____

How were you referred to our office? _____ **Family Medical Doctor:** _____

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:

List persons here: _____

Patient Signature: _____ **Date:** _____

History of Present and Past Illness

Reason(s) for visit: _____ **Date symptoms appeared:** _____

Is this due to: Auto___ Work___ Other _____ **Have you ever had a similar condition?** ___ No ___Yes

Date of last physical examination: _____ **Days lost from work:** _____

Do you have a history of stroke or high blood pressure? ___No ___Yes

Have you had any major illnesses? ___Cancer ___Diabetes ___Heart Disease ___Other: _____

Have you had any surgeries? ___No ___Yes, describe: _____

Have you been hospitalized? ___No ___Yes, describe: _____

Have you had any major injuries or falls? ___No ___Yes, describe: _____

Have you been in any auto accidents? ___No ___Yes, when? _____

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

If yes, describe: _____

What medications or nutritional supplements are you taking? _____

_____

Have you used corticosteroids (Cortisone, Prednisone, etc.)? ___No ___Yes, describe: _____

Do you have allergies of any kind? ___No ___Yes

If yes, describe: _____

Do you have any Congenital Condition? ___No ___Yes, please describe: _____

***Women*: Are you pregnant?** ___No ___Yes

Please give information about any childbirths with dates: _____

SOCIAL HISTORY

What type of regular exercise do you perform? ___Light ___Moderate ___Vigorous ___None
Are you on a special diet? ___No ___Yes, describe: _____ **How many cups of water do you drink per day?** ____
Do you drink caffeinated beverages? ___No ___Yes, drinks per day? ____ per week? ____ per month? ____
Do you drink alcohol? ___No ___Yes, drinks per day? ____ per week? ____ per month? ____
Do you use any recreational drugs? ___No ___Yes
Do you use tobacco of any kind? ___Never ___In the past ___Current user (__often or __sometimes)
How many hours of sleep are you getting per night? ___less than 5 ___6-8 ___8-10 ___10 or more
How would you rate your sleep? ___wake fully rested ___wake moderately rested ___wake poorly rested
How would you rate your stress level (please circle)? No Stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressed
List your major stressors: _____ **What are your health goals?** _____

Family History

Please indicate if an immediate family member has had any of the following: ***(list family member(s) and describe)***

Cancer: _____ **Heart Problems:** _____

Diabetes: _____ **Other:** _____

Review of Systems

Please indicate if you have any of the following with:

Constitutional	__none __chills __daytime drowsiness __fatigue __fever __loss of appetite __night sweats __weight gain / loss __fainting __excessive thirst __headaches __frequent urination __other: _____
Eyes, Vision	__none __blind spots __cataracts __double vision __wears contacts / glasses __itching __tearing __other: _____
Ears, Nose, Throat	__none __nosebleeds __ear discharge __loss of smell __dizziness __runny nose __hearing loss __nasal congestion __headaches __sinus pain __ear pain __history of head injury __sore throat __loss of taste __other: _____
Respiratory	__none __sputum production __asthma __shortness of breath __cough __coughing up blood __wheezing __other: _____
Cardiovascular	__none __high blood pressure __heart attack __stroke __Pacemaker __low blood pressure __circulation issues __heart disease __heart murmur __chest pains/tightness __palpitations __other: _____
Gastrointestinal	__none __diarrhea __constipation __abdomen pain __loss of appetite __ulcers __jaundice __indigestion __abnormal stool __difficulty swallowing __belching __heartburn __hemorrhoids __rectal bleeding __gallbladder issues __liver issues __other: _____
Female	__none __on birth control __menstrual difficulties __kidney or bladder issues __hormone therapy __menopause __other: _____
Male	__none __kidney issues __bladder issues __prostate problems __other: _____
Skin	__none __itching __lesions/ulcers __numbness __rash __shingles __hives __bruises __skin disorder __hair loss __other: _____
Neurologic	__none __numbness __memory loss __stroke __dizziness __weakness __balance loss __fainting __headache __seizures __sleep disturbance __other: _____
Psychologic	__none __confusion __loss of appetite __memory loss __anxiety __insomnia __mood change __eating disorder __stress __depression __nervousness __other: _____
Hematologic	__none __bleeding __blood clotting __blood transfusion __anemia __fatigue __bruise easily __lymph node swelling __other: _____
Musculoskeletal	__none __arthritis __Rheumatoid arthritis __joint pain/swelling __osteoporosis (weak bones) __other: _____
Endocrine	__none __Cushing's disease __diabetes __excessive thirst __constantly hot or cold __heat or cold intolerant __hyperparathyroidism __hyperthyroidism __hypothyroidism __increased foot or hand size __increased urination __pancreatic conditions __polydipsia __polyuria __purple straie __steroid treatments __testosterone deficiency __thyroid problems

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

Patient Signature: _____ **Date:** _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

_____ **(INITIAL)** I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me, by anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by a licensed Physician of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with the office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of all healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

HIPAA CONSENT

_____ **(INITIAL)** The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA (a copy is located in waiting room) and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The initial does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

X-RAY CONSENT

_____ **(INITIAL)** I hereby acknowledge O'Kane Chiropractic has informed me of the advisability of, risk, inherent in, and the probable consequences of X-rays. They have explained to me the reasons and need for such x-rays. With my understanding I am giving O'Kane Chiropractic my consent to take X-rays.

I certify the information above is correct:

Patient Signature: _____ Date _____

If patient is a minor or under a guardianship order as defined by State law:

Patient Name: _____ **By**: _____

Signature of Parent/Guardian (circle one)

APPOINTMENT NOTICE

To improve efficiency and keep healthcare cost affordable, any appointment that is missed without notification will result in a missed appointment charge. This fee is $40.00 and cannot be filed with your insurance company.

In order to maintain the quality of care that is received at O'Kane Chiropractic, any appointment that is more than 10 minutes late without notification will result in a late charge. This fee is $20.00 and cannot be filed with your insurance company.

You will receive one warning before the charge is applied.

Thank you for your respect and cooperation.

_____ _____

Patient Signature Date

_____

Print Name