

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name: *(First MI Last)* \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_ Work: \_\_\_\_\_  
 Email: \_\_\_\_\_ Gender: M / F Marital Status: Single / Married / Other  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Student Status: Full Student / Part Student / Non-Student Employed: Y / N  
 Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline Preferred Language: English / Decline / Other: \_\_\_\_\_  
 Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline  
 \*Referred By: *(Name)*: \_\_\_\_\_ Family / Friend / Co-Worker / Doctor / Other Source

## EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* \_\_\_\_\_ 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

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

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: \_\_\_\_\_

## RESPONSIBLE PARTY

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

*Other than Self:*

Name: *(First MI Last)* \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*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:** \_\_\_\_\_

**Describe any Secondary Complaints:** \_\_\_\_\_

**Describe WHEN and HOW this began:** \_\_\_\_\_

**Grade Intensity/Severity of Complaint:** None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

**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 diagnostic testing? X-rays / MRI / CT / Other: \_\_\_\_\_ When and Where? \_\_\_\_\_

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

**Medications and Supplements:**

**Allergies to Medications:** **NONE**

Name	Reaction

**Current Medications & Supplements:** **NONE**

Name	Dosage	Frequency	Method

**Family Health History:**

**N/A**

List relevant major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

**Social and Occupational History:**

**Smoking/Tobacco Use:** Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

**Education:** High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

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

**Number of Falls in the last 24 months:** \_\_\_\_\_ **Injuries?** Y or N

**Surgeries:** **NONE**

Date	Area of the Body	Reason

**Major Injuries / Traumas / Hospitalizations:** **NONE**

Date	Describe

**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 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
- 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:**

Date	Outcome

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: \_\_\_\_\_

### 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. I understand that a clinical summary report (CCR) is created after each visit for the purpose of electronic health records (EHR) and is available for my review. At this time, I am asking Foster Chiropractic to save these electronically for me and not print them out after each visit. I understand, upon request, that these reports are available to be printed or emailed to me for review.

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.

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 settlements, claim(s), judgments, or verdicts) resulting from any identified accident The Insurance Carrier is instructed that pursuant to this 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 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: \_\_\_\_\_