# CASE HISTORY

## PATIENT INFORMATION

Date_____

Patient Name_____

Address_____

City_____ State_____ Zip_____

SS#_____

Email_____

Home Phone_____

Work Phone_____

Cell Phone_____

☐ May we send you appointment and event reminders via text messages?

Sex: ☐ M ☐ F Age_____

Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Divorced

☐ Separated ☐ Minor ☐ Partnered for ____years

Employer/School_____

Occupation_____

Spouse's Name_____

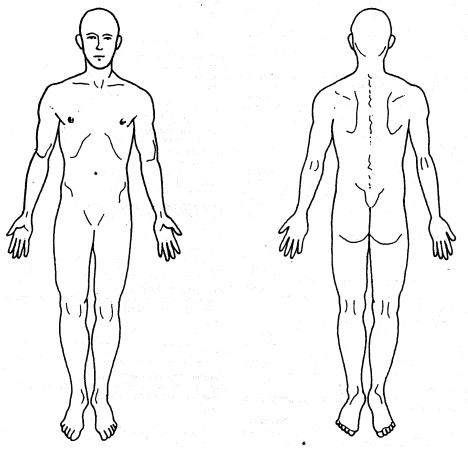
Spouse's Birthdate_____

How did you hear about the office?_____

## SEVERITY OF PAIN

Please mark the areas of pain on the drawing using the code listed.

Burning (+++) Stabbing(000) Sharp(---) Aching(////)



Please list the areas of pain below under AREA. Write a number between 1 and 10 indicating the SEVERITY of the pain, "1" being minor pain and "10" being the worst pain imaginable. Also, write a percentage of how often you feel the pain. "0%" being never, and "100%" being constant.

| | AREA | SEVERITY | % |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |

**Please check or place an "X" for all the symptoms that currently apply to you.**

| | | | | |
|---|---|---|---|---|
| ☐ Stiff Neck | ☐ Swollen ankles | ☐ Dizziness | ☐ Constipation | ☐ Asthma |
| ☐ Neck Pain | ☐ Poor Circulation | ☐ Convulsions | ☐ Diarrhea | ☐ Frequent Colds |
| ☐ Middle Back Pain | ☐ Varicose Veins | ☐ Loss of Sleep | ☐ Hemorrhoids | ☐ Thyroid Trouble |
| ☐ Lower Back Pain | ☐ Stroke | ☐ Fatigue | ☐ Liver Trouble | ☐ Tonsillitis |
| ☐ Arm Pain | ☐ Heart Attack | ☐ Loss of Weight | ☐ Jaundice | ☐ Sinus Trouble |
| ☐ Arm Numbness | ☐ Itchy Skin | ☐ Allergies | ☐ Gall Bladder trouble | ☐ Cough |
| ☐ Leg Pain | ☐ Bruise Easily | ☐ Weakness | ☐ Poor Vision | ☐ Short of Breath |
| ☐ Leg Numbness | ☐ Boils | ☐ Twitching | ☐ Pain in Eyes | ☐ Frequent Urination |
| ☐ Swollen Joints | ☐ Sensitive Skin | ☐ Poor Appetite | ☐ Deafness | ☐ Painful Urination |
| ☐ Painful Tailbone | ☐ Hives | ☐ Poor Digestion | ☐ Earache | ☐ Blood in Urine |
| ☐ Foot Pain | ☐ Eczema | ☐ Excessive Hunger | ☐ Ear Noises | ☐ Kidney Infections |
| ☐ Rapid Heartbeat | ☐ Headaches | ☐ Belching or Gas | ☐ Nosebleeds | ☐ Bed Wetting |
| ☐ Slow Heartbeat | ☐ Fever | ☐ Nausea | ☐ Sore Throat | ☐ Incontinence |
| ☐ High Blood Pressure | ☐ Night Sweats | ☐ Vomiting | ☐ Hoarseness | ☐ Prostate Trouble |
| ☐ Chest Pain | ☐ Fainting | ☐ Stomach Pain | ☐ Hay Fever | ☐ Bladder Infections |

**WOMEN ONLY**

☐ Painful Periods
☐ Excessive Flow
☐ Irregular Cycles
☐ Hot Flashes
☐ Cramps
☐ Vaginal Discharge
☐ Currently Pregnant
☐ Breast implants

Date of Last Pap:
_____

# HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and Location of other doctor(s) who have treated you for your condition _____

_____

**Date of Last:** Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

List any broken bones or dislocations: _____

Have you ever had a spinal tap or injection? ☐ Yes ☐ No

Have you ever been knocked unconscious? ☐ Yes ☐ No

Have you ever had a lapse in memory? ☐ Yes ☐ No

Have you ever had X-Rays, MRI or CAT Scans of your spine? ☐ Yes ☐ No When?_____

Do you Suffer from any condition other than that for which you are consulting us? _____

# ACCIDENTS, INJURIES, AND FALLS

**Please list any accidents, injuries, falls, and the dates**

☐ Car: _____

_____

☐ Sports: _____

_____

☐ Work / School:_____

_____

☐ Other:_____

_____

# EXERCISE AND WORK ACTIVITY

| **Exercise** | **Work Activity** |
|---|---|
| ☐ No Exercise | ☐ Sitting |
| ☐ Moderate | ☐ Standing |
| ☐ Daily | ☐ Light Labor |
| ☐ Heavy | ☐ Heavy Labor |
| Describe: _____ | Describe: _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

# MEDICATION

_____

_____

_____

Pharmacy Name_____

Pharmacy Phone_____

# ALLERGIES

_____

_____

_____

_____

_____

# HABITS

☐ Smoking Packs/Day _____

☐ Alcohol Drinks/Week_____

☐ Coffee/Caffeine Drinks Cups/Day_____

☐ High Stress Level Reason_____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the doctor to examine me and treat my conditions as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: _____ Date: _____

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. 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 we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect 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.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give 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 Date

# INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Dynamic Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____