

Chiropractic Case History

Name _____ Sex M F Date _____

Address _____ State _____ Zip _____

Phone _____ Date of Birth _____ Social Security # _____

Email _____ Referred by/ how did you find us? _____

Occupation _____ Employer _____

What is the best way to contact you? (circle one) Call / Text / Email

Have you ever received Chiropractic Care? Yes / No If yes, when? _____

1. Primary reasons for seeking chiropractic care (what brought you in today?): (circle one)

Pain/ Injury related Wellness/Preventative Health care A little bit of both

2. Tell us more:

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Has the complaint kept you from performing normal tasks? Activities you enjoy? (Ex: Chores, Driving, Sports, Self-Care, Play)

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

4. Past Health History:

A. Previous serious illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

FEMALE PATIENTS ONLY

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

6. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

Does your pain prevent you from taking care of yourself or enjoying normal activities? _____

Expectations of Care? (optional)

What is the end result you hope to achieve with care at this office? _____

What are some secondary benefits you hope to experience? _____

How many visits to our office are you anticipating? _____

How much time per day are you willing to commit to reaching your goal? _____

Once your health goal is achieved what are your expectations for post-care / maintenance? _____

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 of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature _____ Date _____



PETERSON
FAMILY CHIROPRACTIC

HIPAA Notice of Privacy Practices

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices, the HIPAA Compliance Manual, and State/Federal law.

Print Name: _____

Signature: _____

Date: _____



PETERSON
FAMILY CHIROPRACTIC

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We can provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services as part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor uses physical touch or a mechanical device in order to assess and treat musculoskeletal such as muscle tone, joint stability and motion, soft tissue injury, and their relationship to the health of the patient. During treatment you may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, and therapeutic ultrasound or exercise therapies may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Patient’s Rights: At any time the patient reserves the right to have additional questions or concerns addressed, as well as to stop any treatment from being performed without penalty, even if prior treatment has taken place. The doctor makes all treatment decisions in good faith and with best evidence based treatment protocols and outcomes in mind. All recommendations are based off those protocols. At all times patient comfort and health is at the forefront of any treatment and as such the patient has the right to revoke consent prior to treatment being rendered.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name

Signature

Date

WITNESS:

Printed Name

Signature

Date