Chiropractic Case History

Name_____ Sex __M __F Marital Status: S M D (other) DATE:_____
Address_____City_____State_____Zip_____
H. Phone_____W. Phone_____ Cell _____ Date of Birth_____Age_____
Email _____Referred by_____ Social Security #_____
Occupation_____Employer_____
Emergency Contact Name_____ Phone #_____

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

1. Primary reasons for seeking chiropractic care:

Primary Condition: _____
Condition 2: _____
Condition 3: _____
Condition 4: _____

The above condition(s) are due to Auto Accident: YES NO or Work Related Injury YES NO
Condition(s) began when and how? _____
Please circle the Quality of the complaints/pain: dull aching sharp shooting burning throbbing deep nagging other _____
Does this conditions/pain radiate or travel (shoot) to any areas of your body? YES NO Where?_____
Do you have any numbness or tingling in your body? YES NO 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 are condition(s) present, how long does it last? _____
Does anything aggravate the condition(s)? YES NO _____
Does anything make the condition(s) better? YES NO _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your condition(s): _____
_____

3. Past Health History:

A. Previous 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
_____	_____
_____	_____
_____	_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____

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

Are you Pregnant Now? YES NO

4. Family Health History:

Associated health problems of relatives *(circle)*: Cancer Heart Diabetes Other_____

Deaths or Health Problems in immediate family:

Mother Cancer Heart Diabetes Other_____

Father Cancer Heart Diabetes Other_____
Sibling Cancer Heart Diabetes Other_____

5. Social and Occupational History:

A. Level of Education: O high school O some college O college graduate O post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle *(circle)*:

How often do you exercise?	Daily	Weekly	Sometimes	Never
How often do you drink alcohol?	Daily	Weekly	Sometimes	Never
How often do you smoke?	Daily	Weekly	Sometimes	Never
Do you use recreational drugs?	Yes	No		
How is your diet?	Healthy	Healthy Sometimes	Fast Food	

Do you have Insurance? YES NO Insurance Carriers Name:_____

Functional Rating Index

For use with neck and/or back problems only. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0- No Pain **1-** Mild Pain **2-** Moderate Pain **3-** Severe Pain **4-** Worst Possible Pain

2. Sleeping

0- Perfect Sleep **1-** Mildly Disturbed **2-** Moderately Disturbed **3-** Greatly Disturbed **4-** Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions **1-** Mild Pain; No Restrictions **2-** Moderate Pain; Go Slowly **3-** Moderate Pain; Some Assistance **4-** Severe Pain; 100% Assistance

4. Travel (driving, etc.)

0- No Pain on Long Trips **1-** Mild Pain on Long Trips **2-** Moderate Pain on Long Trips **3-** Moderate Pain on Short Trips **4-** Severe Pain on Short Trips

5. Work

0- Usual Work + Extra **1-** Usual Work, No Extra **2-** 50% of Usual Work **3-** 25% of Usual Work **4-** Cannot Work

6. Recreation

0- All Activities **1-** Most Activities **2-** Some Activities **3-** Few Activities **4-** No Activities

7. Frequency of Pain

0- No Pain **1-** Occasional (25%) **2-** Intermittent (50%) **3-** Frequent (75%) **4-** Constant (100%)

8. Lifting

0- No Pain with Heavy Weight **1-** Increased Pain with Heavy Weight **2-** Increased Pain with Moderate Weight **3-** Increased Pain with Light Weight **4-** Increased Pain with Any Weight

9. Walking

0- No Pain with Any Distance **1-** Increased Pain after 1 Mile **2-** Increased Pain after ½ Mile **3-** Increased Pain after ¼ Mile **4-** Increased Pain after Any Distance

10. Standing

0- No Pain with Any Time **1-** Increased Pain after Several Hours **2-** Increased Pain after 1 Hour **3-** Increased Pain after ½ Hour **4-** Increased Pain after Any Time

Total _____ (/4, X10) = Functional Rating Score _____%

Comprehensive Medical History

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.

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

REVIEW OF SYSTEMS

GENERAL APPEARANCE

□ Weight Loss □ Weight Gain □ Change in Sleeping Patterns □ Change in Activity Capacity

NEUROLOGICAL

□ Anxiety □ Headaches □ Depression □ Meningitis □ Paralysis □ Seizure □ Stroke □ Tingling □Tremors □ Memory Loss □ Fainting spells □ Dizziness □ Head injuries □ Blackouts or near blackouts □ Change in sensation anywhere on your body □ Localized weakness or numbness

EARS, EYES, NOSE, & THROAT

□ Hay fever □ Glaucoma □ Polyps □ Allergy □ Cataracts □ Goiter □ Hoarseness □ Double vision □ Gum problems □ Eye problems □ Ear Infections □ Glasses/contacts □ Hearing Loss □ Ear discharge/pain □ Frequent nosebleeds □ Ringing in your ears □ Sinus infections □ Swollen glands

CARDIOVASCULAR

□ Angina □ Leg cramps □ Ankle swelling □ Awakening at night short of breath & getting out of bed □ Cardiac catheterization □ Cold hands or feet □ Congenital heart defects □ Dizziness when standing up quickly □ Heart attacks □ Heart failure □ High or low blood pressure □ Irregular heart rate □ Purple fingers or lips □ Leg pain that resolves with rest □ Heart palpitations □ Varicose veins □ Chest pains □ Murmurs

RESPIRATORY

□ Asthma □ Breathlessness when lying flat □ Prolonged cough □ Coughing up blood □ Emphysema □ Shortness of breath □ Tuberculosis □ Pneumonia □ Frequent infections (bronchitis) □ Wheezing □ Pleurisy

SKIN

□ Abscess □ Dandruff □ Acne □ Oily skin □ Boils □ Rashes □ Hives □ Dry skin □ Lumps □ Psoriasis □ Jaundice □ Athlete's foot □ Excessive body odor □ Excessive sweating □ Fungal infections □ Nail problems □ Moles- irregular □ Moles - change/new

KIDNEYS & URINARY TRACT

□ Blood in urine □ Brown urine □ Dribbling after urination □ Painful urination □ Excessive thirst □ Involuntary urination/incontinence □ Urinating frequently (day) □ Urinating frequently (night) □ Urine hesitancy □ Weak flow □ Frequent bladder infections □ Kidney disease □ Kidney stone

ENDOCINE

□ Diabetes □ Sickle cell □ Abnormal body hair □ Changes in skin texture □ Cold intolerance □ Heat intolerance □ History of "borderline" diabetes

MUSCULOSKELETAL

□ Anemia □ Arthritis □ Back pain □ Bursitis □ Gout □ Joint aches □ Neck pain □ Tendinitis □ Abnormal Blood Counts □ Blood clots in legs/lungs □ Bone Marrow Biopsy □ Easy Bleeding □ Easy bruising □ Joint swelling □ Morning stiffness □ Muscle aches

GASTROINTESTINAL

□ Diarrhea □ Reflux □ Ulcers □ Hepatitis □ Abdominal pain □ Anal fissures □ Black tarry stools □ Vomiting blood □ Constipation □ Nausea □ Problems swallowing □ Hiatal Hernia □ Intestinal obstruction □ Liver disease □ Hemorrhoids □ Red blood after bowel movements □ Gallstones □ Vomiting □ Heartburn □ Indigestion

MALE & FEMALE

□ Painful sexual intercourse □ Loss of sexual interest □ Unprotected sex □ Groin itching □ Sexually transmitted diseases

MALES ONLY

□ Hernia □ Sterility □ Bloody ejaculation □ Inability to complete intercourse □ Lump on testicle □ Penile discharge □ Problems maintaining or keeping an erection □ Prostate disease □ Sores on penis or warts □ Testicular pain □ Testicular swelling

FEMALES ONLY

□ D & C □ Hot flashes □ Hernia □ Fibroids □ Abnormal bleeding between cycles □ Abnormal pap smear □ Bleeding after intercourse □ Complications w/ pregnancy □ PMS □ Endometriosis □ Heavy bleeding during cycles □ Discharge from breast □ Ovarian cysts □ Pelvic Inflammatory Disease □ Postmenopausal symptoms □ Vaginal discharge □ Vaginal Dryness □ Vaginal warts

Not Listed Above:_____

_____

I the above signed affirm the above is true (*patient signature)* Date

Provider's Comments: _____

_____

Providers Name Date

History Documentation - Review of Systems:
99202 = P/N for system 99203 = 2-9 systems 99204/99205 = 10 systems

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Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) 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 PHI 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.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

☐ I, _____(print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

☐ I, _____(print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: X_____ Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

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. In the event that your insurance company does not pay in a timely manner, 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 of Rights and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

I instruct checks to be made payable to FortView Chiropractic Clinic, and payment to be sent to 1714 Fortview Rd., Suite102 Austin, Texas 78704. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. 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 and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Patient or Parent Signature: X_____ Date: _____

Informed Consent for 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".

• I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of FortView Chiropractic Clinic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: X_____ Date: _____