CHIROPRACTIC CASE HISTORY

Confidential Patient Information: Today's Date: _____

Name: _____ Phone: ( ) _____ Cell: ( ) _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Marital: M S W D

Gender: M F Age _____ Date of Birth: ___/___/___ SS#: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: ( ) _____

E-mail address: _____ May we contact you with info? e-mail_____ phone _____ mail_____

Whom may we thank for your referral? _____

Spouse or Legal Guardian:

Name: _____ Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

Date of Birth: _____/_____/_____ SS#: _____

Emergency Contact (NOT LIVING WITH YOU):

Name: _____ Phone: ( ) _____

Relation to Patient: _____ Work Phone: ( ) _____

Payment Method: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Insurance:

Primary Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Secondary Insurance Company: _____

Insured's Name: _____ ID/Policy #: _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Insurance Cases: On all insurance the deductible must be met in the beginning unless prior arrangements are made.

Responsible Party: (Complete this section if you are NOT the patient but ARE responsible for the bill)

Name: _____ Relation to Patient: _____

Home Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Ph: ( )_____ Cell Ph: ( )_____ Work Ph: ( )_____

Employer Name: _____ Occupation: _____

Signature: (Patient, Parent, Legal Guardian or Responsible Part)

I request services X _____ Date: _____

Health History Review

Purpose of this visit _____

Is the condition due to *employment*? _____ **Is the condition due to an *auto accident* or other accident?** _____

Days lost from work _____ Date of accident or symptoms began _____ When did you first notice this problem? _____

How did it occur? _____ Has it become worse recently? _____

If yes, when and how? _____

How frequent is the condition? _____ How long does it last? _____

Are there any other conditions or symptoms you have that may be related to your MAJOR symptoms? _____

Are there other unrelated health problems? _____

Is there anything you can do which seems to provide relief? _____

What seems to make the problem worse? _____

Other doctors you have seen for this condition _____

What medications or drugs are you now taking? _____

Date of last physical exam _____

What operations have you had and when _____

Serious Illness _____

Have you had any broken bones? _____ If yes, list them and give dates _____

List any major accidents you have had other than those listed above _____

Have you ever suffered from: (check all that apply)

Dizziness _____	Arthritis _____	Digestive Disorders _____	Hernia _____	Cancer _____
Backaches _____	Headaches _____	Nervousness _____	Neuritis _____	
Heart Trouble _____	Numbness _____	Sinus Trouble _____	Rheumatic Fever _____	
Diabetes _____	Asthma _____	Anemia _____	Pain or Tingling in arms/legs _____	

To your knowledge, have you had any diseases, major accidents, or injuries not on this form either in the past or the present?_____ If yes, please explain _____

Women Only:
Are you pregnant or feel there is any possibility that you might be pregnant? _____ If yes, how far along _____

Social History:

Smoking _____ Other tobacco use _____ Alcohol use _____
Drink coffee or tea _____ Diet is: Balanced _____ Not _____
Rest is : Sufficient _____ Not Sufficient _____
Recreation is: Sufficient _____ Not _____
My Family Stress is: Severe _____ Moderate _____ Minimal _____
My job stress is: Severe _____ Moderate _____ Minimal _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non - covered. In the event that this account is turned over for collection, I agree to pay all cost of collection, including reasonable attorney's fees. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature X_____ Date _____

Spouse or Guardian's Signature X_____ Date _____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

Name: _____ Date: _____

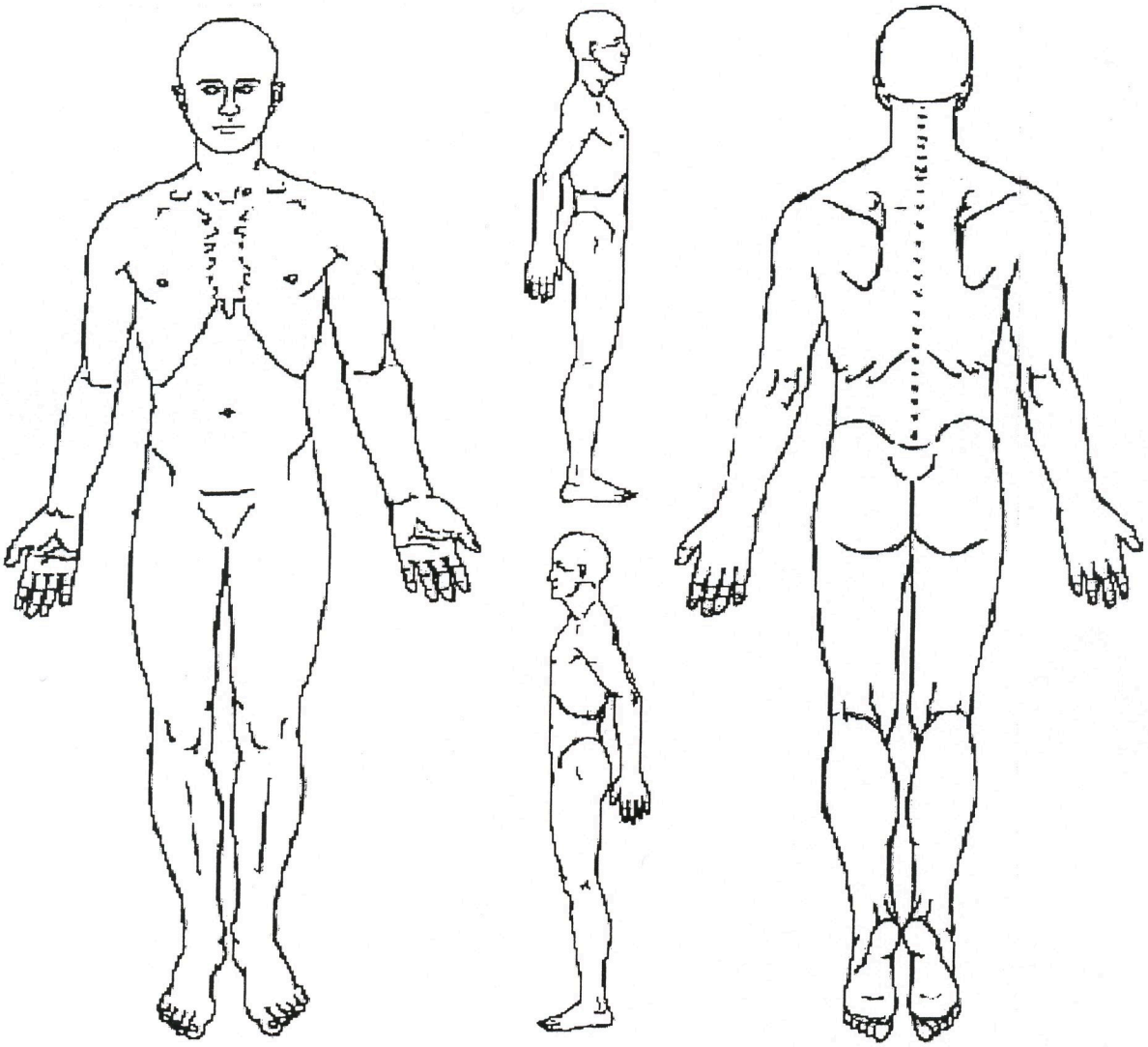
Occupation: _____

How long have you had this pain? _____ Years _____ Months _____ Weeks

Is this your first episode? _____ Yes _____ No

Please rate your pain (circle one): 1 Very Slight 2 Slight 3 Moderate 4 Intense 5 Worst

On the diagrams below **PLEASE MARK WHERE YOU ARE EXPERIENCING PAIN RIGHT NOW.**



Please describe your pain (circle all that apply):

A = ACHING N = NUMBNESS O = OTHER

B = BURNING S = STABBING P = PINS & NEEDLES

A Better Choice Chiropractic / RiverPark Chiropractic
Consent for Use and / or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we always have and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information, including but not limited to exam notes, x-rays, insurance and billing information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed You have the right to review that notice before you sign this consent form (164.520) . We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment **or** by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we do agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be filed in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke authorization. If your were required to give your authorizations as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have been offered a copy of this notice.

_____

Printed Name

X_____ _____

Signature Date

_____ _____

Authorized Provider Representative Date