CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Age ____ Sex ☐ M ☐ F

Address _____ City _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work _____ Cell _____ E-Mail _____

Marital Status: ☐ M ☐ D ☐ S ☐ W Children, Ages _____ Spouse's Name _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine Other _____

Other doctors or therapist who have treated THIS condition _____

What do you think caused this condition? _____

List surgical operations and years: _____

Do you have a family physician? Name _____

Medications, dosage and frequency: _____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N Describe

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ∧∧∧ Numbness ○○○○ Pins/Needles •••• Stabbing //

MARK AN "X" ON THE LINES:

How bad are your symptoms now?

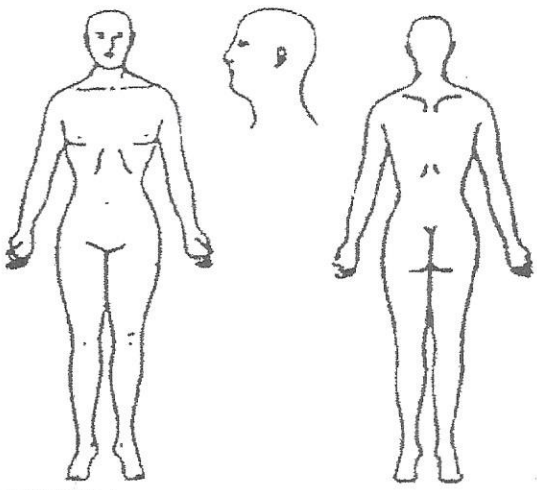
_____

None Most Severe

How bad have they been in the past?

_____

None Most Severe



Signature _____ Date _____

Please circle all symptoms that you have experienced or are currently experiencing.

General
Weakness
Fatigue
Fever
Chills
Night sweats
Fainting

Skin
Color changes
Nail changes
Hair changes
Moles
Rashes
Sores

Head
Headaches
Head injuries
Head bumps
Earaches
Ringing in ears
Discharge from ears
Dizziness
Room spinning

Nose
Decreased smell
Bleeding
Pain
Discharge
Obstruction
Post nasal drip
Runny nose
Sinus congestion

Mouth
Sores
Loss of taste
Dry mouth
Ulcers
Blisters

Throat
Soreness
Hoarseness
Pain
Trouble swallowing

Neck
Neck stiffness
Neck enlargement
Masses
Lumps
Soreness

Endocrine
Weight loss
Weight gain

Lungs
Cough
Phlegm
Blood
Short of breath
Wheezing
Pain
Congestion

Heart
Murmur
Palpitations
Rapid heartbeat
Swollen extremities
Cold extremities
Chest pain/pressure
Varicose veins
Blood clots
Blue extremities

Blood
Anemia
Easy bruising
Easy bleeding
Swollen nodes
Painful nodes
Sugar in blood

Gastrointestinal
Abdominal pain
Nausea
Bloating
Heartburn
Indigestion
Constipation
Diarrhea
Gas
Hemorrhoids
Poor appetite
Bloody stools
Black stools

Genitourinary
Urgency
Incontinence
Straining
Back pain
Frequent voiding
Burning
Discharge
Impotence
Cloudy urine

Women only
Last period: _____

Neurologic
Seizures
Vertigo
Dizziness
Hand trembling
Loss of sensation
Lack of coordination
Loss of facial muscles
Weak grip
Paralysis
Difficulty with speech
Tingling
Memory loss
Numbness

Musculoskeletal
Muscle pain
Muscle weakness
Muscle cramps
Muscle twitching
Joint stiffness
Joint pain

Past Medical History
Mumps
Rheumatic Fever
Allergies
Angina
Cancer
Blood disease
Heart trouble
Phlebitis
Hypertension
Stroke
Jaundice
Gallstones
Liver trouble
Hepatitis
Epilepsy
Paralysis
Depression
Trouble sleeping
Hallucinations
Nervous breakdown
Migraine
Gout
Diabetes
Bladder trouble
Kidney stones
Kidney infection

Please list any allergies

_____

_____

Office Financial Policy

If you do not have insurance All payments are expected at the time of service. If you do have insurance: All deductibles and co-payments are due at the time of service. If your carrier has not paid a claim within sixty days of submission, you agree to take an active part in the recovery of your claim. If your insurance company has not paid within ninety days of submission, you accept responsibility for payment in full of any outstanding balance. Any unpaid balances will be referred to a collection agency for recovery. **We have a 24-hour cancellation policy with our therapist. For any scheduled muscle work or therapeutic exercises, we require a 24-hour notice for cancellation. If unable to cancel appointment before 24 hours, you will be charged for that visit**. My signature at the bottom of this form indicates that I have read and agree to this clinic's financial policy.

Patient name (printed): Patient Signature: Witness:

_____ _____ _____

We offer affordable payment plans! Ask the receptionist about Care Credit!

Informed Consent for Examination & Treatment

I hereby consent to the performance of examination and treatment on me or _____ by the licensed Doctor of Chiropractic and staff who may be employed by or engaged in practice in this clinic. I understand that neither chiropractor nor medical treatment is exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known to be my best interest. I further understand that there are certain degrees of risks associated with chiropractic health care and physical therapy, which rarely includes, but is not limited to fractures, disc injuries, strokes and strains/sprains and am therefore willing to accept and consent to the risk associated with the care I am about to receive. I have read the above information, or it has been read to me. I have had the opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I may seek treatment.

Patient name (printed): Patient Signature: Witness:

_____ _____ _____

Attention female patients: Is pregnancy suspected or confirmed? ☐Yes ☐No

By my signature on this form and checking the appropriate box above, I do hereby declare to the best of my knowledge whether I am pregnant or if pregnancy is suspected at this time.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or 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 undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Attention Car Accident Patients

If we are treating you after a car accident, you will be required to provide the name of the insurance company and a claim number. Providing this information, by printed or verbal means, is giving full consent for Active Life Chiropractic to send all bills, medical records or documentation of your care, including initial intake paperwork, to obtain payment for your care.

Responsible Car Insurance Company: _____

Claim Number: _____

Printed Name: _____

Signature: _____Date:_____