Chiropractic Case History/Patient Information

Date:___________________________ Patient #__________________

Name:__________________________ Social Security #________________ Home Phone:_________________

Address:________________________ City:________________State:______Zip:__________________________

E-mail address:__________________ Fax #________________Cell Phone:______________________________

Age:_____ Birth Date:____________ Race:________________Marital: M S W D

Occupation:____________________ Employer:____

Employer's Address:____________________________________ Office Phone:____________________________

Spouse:____________________Occupation:____________________Employer:___________________________

Number of children:__________Names and ages of children:____

Emergency Contact Name:____________________Address:____________________Phone:________________

How were you referred to our office?____

Family Medical Doctor:____

When doctors work together it benefits you. May we have the permission to update your medical doctor regarding your care at this office? Yes______ No______

Please check any and all insurance coverage that may be applicable:

_____Major Medical _____Worker's compensation _____Medicaid _____Medicare

_____Auto Accident _____Medical Savings Account & Flex Plans _____Other

Name of Primary Insurance Company:____

Primary Insurance Holder's Name & Birth Date:____

Name of Secondary Insurance Company (if any):____

Secondary Insurance Holder's Name & Birth Date:____

AUTHORIZATION & RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers or payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow the chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Heath Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) may have my permission to receive my personal health information:________________________

Patient Signature/Guardian's Signature Authorizing Care: ____________________________________Date:___________

Patient Name: ____Date:______________________

HISTORY OF PRESENT AND PAST ILLNESS:

Chief complaint/purpose of appointment:____

Date symptoms appeared or accident happened:____

What tests have you had for your symptoms & when were they performed?

X-rays date:____________MRI date:____________CT Scan date:___________Other date:___________

Is this due to: Auto_____Work_____Other____

Have you ever had the same or similar condition? _____Yes_____No

If yes when and describe:____

Days lost from work:________________________Date of last physical exam:_____________________________

Do you have a history of stroke or hypertension?____

List any major illnesses, injuries, falls, auto accidents, or surgeries. Women please include information about childbirth (including dates): ____

____

Have you been treated for any health condition by a physician in the last year? _________Yes___________No

List any medications/drugs you are taking:____

____

Do you have allergies to any medications? _______Yes_______No

If yes, describe: ____

Do you have any allergies of any kind?______Yes______No

If yes describe: ____

List any congenital conditions: ____

Women: Are you pregnant? _________________________ Estimated due date: _________________________

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN = "O: SOMETIMES = "S" NEVER = "N"

______Vigorous Exercise ______Moderate Exercise ______Alcohol Use

______Drug Use ______Tobacco Use ______Caffeine

______High Stress Activity ______Family Pressures ______Financial Pressures

______Other Mental Stresses ______Other (specify)____

Patient Name: ____Date:_______________________

Have you had or do you currently have any of the following symptoms or conditions?

	Now	Previously		Now	Previously
Headaches			Numbness in toes		
Neck Pain			High blood pressure		
Stiff Neck			Low blood pressure		
Sleeping Problems			Circulation problems		
Back Pain			Heart disease		
Nervousness			Pacemaker		
Tension			Stroke		
Irritability			Difficulty urinating		
Chest pains/tightness			Weakness in extremities		
Dizziness			Loss of balance		
Shoulder/arm pain			Fainting		
Numbness in fingers			Loss of smell		
Loss of taste			Rheumatoid arthritis		
Unusual bowel patterns			Excessive bleeding		
Feet cold			Osteoarthritis		
Hands cold			Ruptures		
Arthritis			Eating disorder		
Muscle spasms			Drug addiction		
Frequent colds			Alcoholism		
Fever			Gall bladder problems		
Sinus problems			Ulcers		
Indigestion			Weight loss/gain		
Joint pain/swelling			Depression		
Menstrual difficulties			Loss of memory		
Breathing problems			Seizures/epilepsy		
Fatigues			Cancer		
Lights bother eyes			Coughing blood		
Ears ring/buzzing			HIV positive		
Broken bones/fractures			Osteoporosis		

Patient Name: ____Date:_______________________

FAMILY HISTORY

Please review the below-listed conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ]	SISTER(S) Age [ ]	CHILDREN Age [ ] Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High blood pressure						
Insomnia						
Kidney trouble						
Liver trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

____

Check if applicable to you: ____________________**As an adopted child, little is known of birth parents or family.**

I certify the information provided is accurate to the best of my knowledge.

Name of Patient:____

Signature of Patient/Legal Guardian: ____**Date**: ________________

THE QUEBEC PAIN SCALE

Name: __________________________ **Age**: ______ **Date**: ____________**Score**:_______

This questionnaire is about the way your back pain is affecting your life. People with back problems may find it difficult to perform some of their daily activities. We would like to know if you find it difficult to perform any of the activities listed below, because of your back. For each activity there is a scale of 0-5 (0 = normal; 5 = severe). Please choose one response for each activity.

Today, do you find it difficult to perform the following activities because of your back?	0 (no pain)	1	2	3	4	5 (severe pain)
1. Get out of bed						
2. Sleep through the night (at least 6 hours)						
3. Turn over in bed						
4. Ride in a car for 1 hour						
5. Stand up for 20-30 minutes						
6. Sit for 4 hours in a chair						
7. Climb one flight of stairs						
8. Walk a few blocks						
9. Walk 1-2 miles						
10. Reach high shelves						
11. Throw a ball						
12. Run 2 blocks						
13. Take food out of the refrigerator						
14. Make your bed						
15. Put on socks/panty hose						
16. Bend over a sink for 10 minutes						
17. Move a chair						
18. Pull or push heavy doors						
19. Carry 2 bags of groceries						
20. Lift and carry a 40 lb suitcase						
SUBTOTAL =						
TOTAL SCORE =						

Comments (any other activities that are especially painful):

____

____

Patient Name: ___________________________________Age: __________Date: ______________

Check one: ____Initial Examination ____Re-Evaluation ____New Condition

For initial examination or new condition, please give the date you first noticed symptoms___________

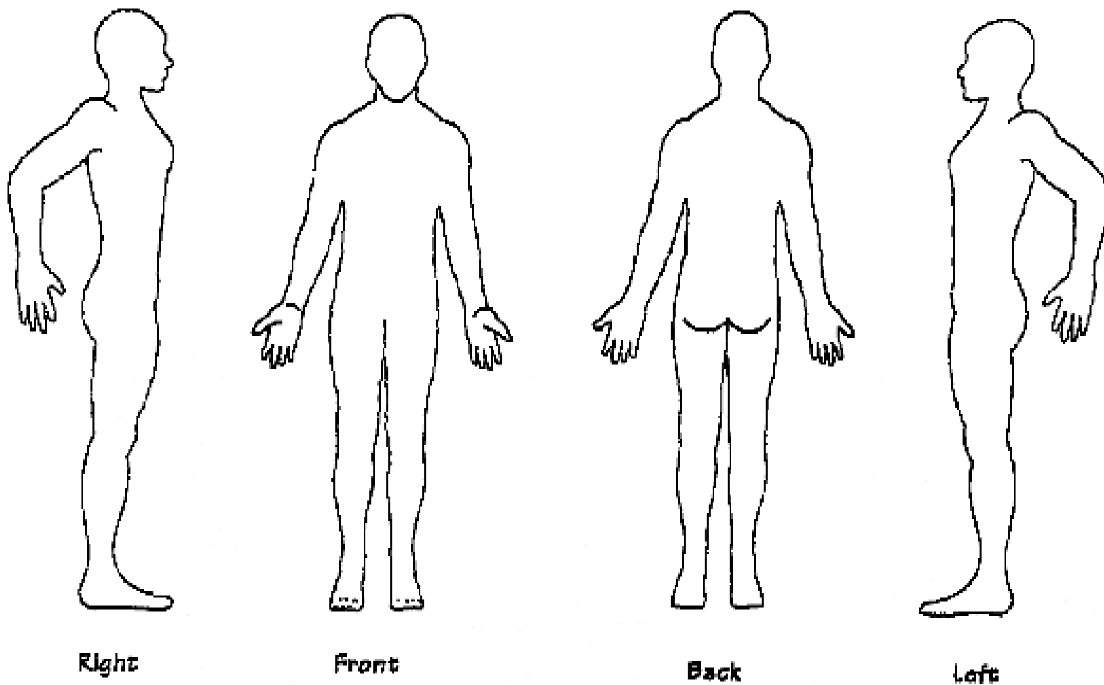
For initial examination or new condition, what is your major complaint? _________________________

SUBJECTIVE PAIN ASSESSMENT

Place an "X" on the drawings wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A= ACHE
B= BURNING
ST= STABBING
SP= SPASM
N= NUMBNESS
P= PINS AND NEEDLES
T= THROBBING

Example: XST between your shoulders mean you have stabbing pain between your shoulders



PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

Patient or authorized representative signature: _____________________________Date: ___________

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

Printed Name: ________________________________ Date: ______________________

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 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___

Patient's Signature: __________________________

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

Signature of Parent/Guardian (circle one) ___________________________

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Discover, Master Card, or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pa varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You my then submit the bill to your insurance carrier for reimbursement.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include but are not limited to, examinations, therapies, orthotics, supports, kinesio tape, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information if a settlement has not been made within 3 months, or if you suspend or terminate care any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Loveland Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Loveland Family Chiropractic and my insurance company. I request that Loveland Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Loveland Family Chiropractic that fees will be due and payable immediately.

Patient's Signature (or guardian if patient is a minor)_____________________________ Date: ________

Witness: ____Date:________