

# CONFIDENTIAL PATIENT CASE HISTORY

## PERSONAL INFORMATION:

Today's Date \_\_\_\_\_ Name \_\_\_\_\_ Birthday \_\_\_\_\_ Sex MF

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail (don't worry we respect your privacy) \_\_\_\_\_

Marital Status:  M  S  D  W Children, Ages \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ How else did you hear about us? \_\_\_\_\_

## REASON FOR YOUR VISIT:

What is your major complaint? \_\_\_\_\_

When did it start? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Is it: (circle all that apply) Sharp Dull Achy Numbing Burning Tingling Other: \_\_\_\_\_

Where exactly is it located? \_\_\_\_\_

Does it radiate Y / N : Where?: \_\_\_\_\_

Do your problems have a timing? (morning, evening, wakes me up etc) \_\_\_\_\_

What are you no longer able to do because of this condition? \_\_\_\_\_

Is this condition:  Improved  Unchanged  Getting Worse

Other doctors or therapist who have treated THIS condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

What is your goal for this condition? \_\_\_\_\_

Is this a result of an auto accident other personal injury? Y/N \_\_\_\_\_

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES TO THE RIGHT:

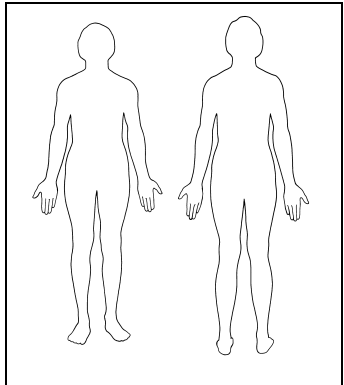
MARK AN "X" ON THE LINES:

How bad are your symptoms now?

-----  
**None** **Most Severe**

How bad have they been in the past?

-----



Front Back

**ABOUT YOUR HEALTH:**

List any spinal or joint surgical operations: \_\_\_\_\_

Are you happy with your health currently Y / N: If no what do want to change? \_\_\_\_\_

\_\_\_\_\_

Mental Work    Heavy Moderate Light    Hours per day \_\_\_\_\_

Physical Work   Heavy Moderate Light    Hours per day \_\_\_\_\_

Exercise            Heavy Moderate Light    Hours per week \_\_\_\_\_ Type \_\_\_\_\_

Current Physicians' Name \_\_\_\_\_ Phone: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATIONS & RELEASES:**

**Notice of Privacy Practices (HIPPA):** (signed by all patients)

I acknowledge that I have been informed that Harbor View Chiropractic's "Notice of Privacy Practices" is enforce and readily available for review in the clinics reception area.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Authorization to Release Health Care Information:** (signed by all patients)

I authorize the release of any health care information needed to process my insurance claims and also certify that all insurance information given to Harbor View Chiropractic to be my policy and accurate.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Request for Payment of Benefits to Provider of Care:** (signed by patients using insurance)

I authorize my insurance company make payments directly to Harbor View Chiropractic for services rendered that are covered under my plan.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Attorney Representation and Protection of Balance:** (signed by patients in a personal injury or workers compensation case)

I, the undersigned patient am directing my attorney/insurance adjuster, \_\_\_\_\_ to pay any Outstanding bills at Harbor View Chiropractic out of my settlement directly to Harbor View Chiropractic. I fully understand that I am ultimately responsible for any charges incurred for services rendered at Harbor View Chiropractic regardless of the settlement of my case.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Consent for Treatment:** (signed by all patients except minors)

I, the undersigned, a patient in this office, hereby authorize, Dr. Eric P. Bassett, and his designated assistants to administer treatment as necessary, and recognize no guarantees are made to for the outcome obtained.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**Consent for Treatment of a Minor:** (signed by guardians of minor aged patients)

I, the undersigned, a patient in this office, hereby authorize, Dr. Eric P. Bassett, and his designated assistants to administer treatment as necessary to my \_\_\_\_\_ named \_\_\_\_\_.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_