

# Chiropractic Case History/Patient Information

Date \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

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

E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Race \_\_\_\_\_ Marital: M S W D How many children? \_\_\_\_\_

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

Employer's Address \_\_\_\_\_ Office Phone \_\_\_\_\_

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

Name of Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_

Date symptoms appeared or accident happened \_\_\_\_\_

Have you ever had the same or a similar condition? Yes No If yes, when and describe: \_\_\_\_\_

\_\_\_\_\_

Days lost from work \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ What surgeries have you had? (Include dates) \_\_\_\_\_

\_\_\_\_\_

Serious illnesses (include dates) \_\_\_\_\_

\_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: \_\_\_\_\_

\_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

\_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case.

Major Medical      Worker's Compensation      Medicaid  
Medicare      Auto Accident      Other

Name of Primary Insurance Company \_\_\_\_\_  
Name of Secondary Insurance Company (if any) \_\_\_\_\_

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

## Informed Consent To Treatment

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Hoang Chiropractic Center is a licensed professional chiropractic clinic. The primary treatment used by the Doctor of Chiropractic is the spinal adjustment. We will use that procedure to treat you.

- **The nature of the Chiropractic Adjustment**

The Doctor of Chiropractic will use her/his hands or a mechanical device upon your body in such a way as to move your joints. This may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **Associated Risks and the Probability of those risks occurring**

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Other complications may include: dislocations, muscle strains, Horner's syndrome, costovertebral strains and separations. These complications are generally described as "rare".

- **Why Chiropractic is important and what you can expect**

Most injuries treated by the Doctor of Chiropractic involve the Musculoskeletal System, however, most therapies involve the care of the muscular portion of this system only. It is essential for all components of a system to function properly as a whole to obtain maximum healing and health potential. An adjustment will "align your spine."

If you have never been adjusted before or, if you have not been adjusted in many years, you may experience some stiffness and soreness following the first few treatments.

- **Ancillary Treatment**

In addition to Chiropractic adjustments we intend to use the following treatments:

- Electrical Stimulation carries the following significant risks: skin reactions (Itchy, red); Interference with blood pressure if treated in the cervical spine; Spread of unknown infection.
- Intersegmental Distraction, Flexion Distraction and Flexion Extension all carry the following significant risks: Aggravation of current condition.

Signature \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. When, or approximately when did the complaint start? \_\_\_\_\_
2. Did the pain begin  gradually, or  suddenly? (check one)
3. Did anything cause or contribute to the onset (accident, fall, etc.)? \_\_\_\_\_
4. Describe the pain (check all that apply)  aching  dull  sharp  burning  
 throbbing  gnawing  piercing  spasm Other: \_\_\_\_\_
5. Does the pain radiate to any other part of your body?  Yes  No
6. From 0 (meaning no pain) to 10 (meaning intense, excruciating pain) how would you rate your pain? \_\_\_\_\_ (0 to 10)
7. Have you ever had pain similar to your current complaint before? (Please describe)
8. Is your condition  constant, or  intermittent (occurs on and off)?
9. What makes your pain decrease? \_\_\_\_\_
10. What makes your pain increase? \_\_\_\_\_
11. Has there been any changes in your bodily functions?  Urination  Defecation  
 Vision  Respiration  Digestion Other: \_\_\_\_\_
12. Does your condition affect your daily activities?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
13. Are you taking any medications? (Specify) \_\_\_\_\_
14. Do you have any allergies? (Specify) \_\_\_\_\_

Please circle Yes or No if you have any of the following conditions:

- |  |          |
|--|----------|
| A. Arteriosclerosis (plagues in your arteries)         | Yes / No |
| B. Hypertension (high blood pressure)                  | Yes / No |
| C. Heart Disease                                       | Yes / No |
| D. Cervical Spine Spondylosis (arthritis of the spine) | Yes / No |
| E. Family history of strokes                           | Yes / No |
| F. Unexpected weight loss/gain                         | Yes / No |

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of your policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient

Date