

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient: please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept you as a patient. Thank You.

Full Name: \_\_\_\_\_ Called: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F

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

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SSN#: \_\_\_\_\_ Marital Status: S M P W D Sep Spouse/Partner's name: \_\_\_\_\_

Your Employer: \_\_\_\_\_ Your Occupation: \_\_\_\_\_

Employer address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Person responsible for this account: \_\_\_\_\_ Referred By: \_\_\_\_\_ E-mail: \_\_\_\_\_

History of Present Injury/Illness: Please list below the complaint(s) you have in order of importance, also the length of time you had these complaint(s).

- 1. \_\_\_\_\_ How Long? \_\_\_\_\_
2. \_\_\_\_\_ How Long? \_\_\_\_\_
3. \_\_\_\_\_ How Long? \_\_\_\_\_
4. \_\_\_\_\_ How Long? \_\_\_\_\_

Is your condition related to an accident? Yes No If yes describe: \_\_\_\_\_

Ever had a similar episode before? Yes No Describe your condition: getting worse the same getting better constant comes + goes

What activities aggravate your condition? \_\_\_\_\_ What makes your condition better? \_\_\_\_\_

Is this condition interfering with your: Work Sleep Daily routine Other: \_\_\_\_\_

Have you seen any other health care provider for your present condition? Yes No Who? \_\_\_\_\_

List previous diagnoses and treatments you have received for your present condition? \_\_\_\_\_

List all medications you presently take: \_\_\_\_\_

Age of your mattress: \_\_\_\_\_ type of mattress: \_\_\_\_\_ Comfortable Uncomfortable Are you wearing: heel lifts arch supports

Past History: List any surgeries you have had

- 1. \_\_\_\_\_ Date: \_\_\_\_\_ 3. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_ 4. \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever been involved in a motor vehicle accident? Past year Past five years Over five years Never

Describe: \_\_\_\_\_

Table with 3 columns: Question, Yes, No, Describe Briefly. Rows include: Been knocked unconscious, Used a crutch, cane, or other support, Been treated for a spine or nerve disorder, Had a fracture or broken bone, Hospitalized other than surgery.

Table with 3 columns: Question, Yes, No, Describe Briefly. Rows include: Now take vitamins, minerals, or herbs, Think you may need supplements, Have an allergy to any drug?

Table with 6 columns: Habits, Heavy, Moderate, Light, None, Comments. Rows include: Alcohol, Coffee, Tobacco, Drugs, Exercise, Appetite.

In case of an emergency who should we contact?

Name: \_\_\_\_\_

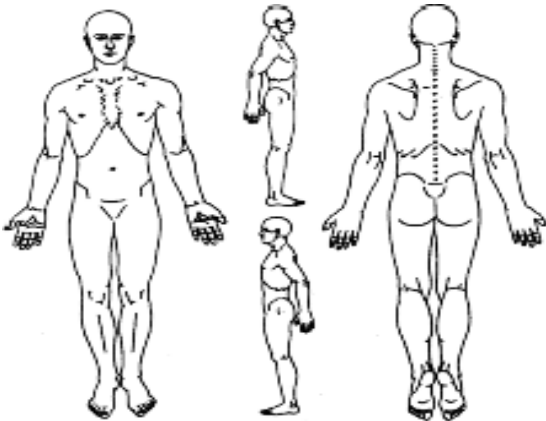
Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

## CONFIDENTIAL PATIENT CASE HISTORY

Please check the appropriate box for any of the following symptoms which you have now or have had previously. We want all the facts about your health before we accept your case. This is a confidential health report.



On the drawing to the right, circle the area(s) where you have pain. Then, *for each area that you have circled*, designate a number from 0 to 10 (with 10 being the most pain) that corresponds to your *current* pain level.

0-10	Burning	Sharp	Numb	Tingling	Ache	Other
___ Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Low back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P – Previous C – Current

- P C
- General**
- Allergy / Hay fever
  - Convulsions / Tremors
  - Dizziness
  - Depression / Anxiety
  - Fainting
  - Fatigue
  - Insomnia
  - Loss of Weight
  - Night Sweats
- Muscle & Joint**
- Arthritis
  - Bursitis / Swollen Joints
  - Night Pain
  - Muscle cramps at night
  - Muscle weakness
  - Scoliosis
  - Stiffness
  - Surgical implant

- P C
- Gastro-Intestinal**
- Belching or gas
  - Bloating after meals
  - Constipation / Diarrhea
  - Gall bladder removed
  - Colitis
- EENT**
- Deviated septum
  - Frequent colds / ear infections
  - Nosebleeds
  - Tinnitus
- Endocrine**
- Afternoon headaches
  - Crave salt
  - Coarse or thinning hair
  - Get “shaky” if hungry
  - Inability to concentrate
  - Increase in weight
  - Sensitive to cold
- Skin**
- Bruise easily
  - Hives / rash

- P C
- Cardio-Vascular**
- Asthma
  - Chest Pain
  - Chronic cough
  - Difficulty breathing / Wheezing
  - Hardening of arteries
  - High / Low blood pressure
  - Pain over heart / chest pain
  - Spitting up blood / phl egm
  - Swelling of ankles
- Genito-urinary**
- Bed-wetting
  - Unable to control kidneys
  - Painful urination
  - Frequent urination
  - Prostate trouble
- For Women Only**
- Hot flashes
  - Irregular / Painful / Excessive menses
  - Painful breasts
  - Premenstrual tension
- Yes  No Are you pregnant?

**Family History: Check the following condition that applies for you, mother, and father**

	You	Father	Mother	explain
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Pace maker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

- I allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office authorization to use my name for any in-office publications.
- Authorization may be denied or retracted at any time by notifying the office manager.
- I authorize payment of medical benefits to this office.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian’s signature: \_\_\_\_\_

Date: \_\_\_\_\_

(Authorization expires 3 years from above date)

# Baker Chiropractic & Acupuncture

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please review it carefully.

A signed consent form permits us to use your personal health information within our office for the purposes of treatment, receiving payment, and health care operations of our practice.

It is the policy of this practice to release only the minimum necessary information to any source not directly linked to hands on care and treatment of patients in our office as outlined in the Health Insurance Portability Accountability Act of 1996 (HIPAA). This includes third party payers, insurance companies, etc. In these cases your signed consent form permits us to release only enough information to complete the insurance claim process.

In some cases, patients may wish to have their protected health information released. In those cases if the outside entity can provide us with a copy of a medical records release form signed by the patient then we will comply while still providing only the minimum necessary information, or the amount of information requested by the patient.

In cases of public health, HIPAA does not protect some information. Where we are required by law to release information to any law enforcement or public health agency, our office will only release the minimum information required by law to any outside entity. In all cases we will follow the most restrictive laws, state or federal, that apply in protecting your medical information.

You, as a patient have a right to see your medical record during normal office hours.

### ADDITIONAL USES OF YOUR HEALTH INFORMATION

Our staff may use your health information to remind you of appointments, send birthday or seasonal greeting cards, mailings, newsletters, information about our practice or other information we feel you may be interested in or may improve your health. We will not release a mailing list to any outside entity for solicitation of business not related to our office.

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.

This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.

HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.

You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

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

Restrictions:

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's polices and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Baker Chiropractic & Acupuncture

## Consent Agreement

### ***Consent for Treatment***

I understand that my outpatient registration, treatment or series of treatments by Baker Chiropractic & Acupuncture is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff.

### ***Consent for treatment of a Minor***

I (We) being the parent, guardian, or custodians of \_\_\_\_\_, a minor, the age of \_\_\_\_\_, do hereby authorize, request and direct Dr. Baker to perform in his/her judgment and necessary examinations, x-rays and recommended treatment for the condition.

### ***Request for Records***

I hereby authorize Dr. Baker and Baker Chiropractic & Acupuncture to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physician, and health care providers.

### ***Payment & Insurance Release***

I permit a copy of this authorization to be used in place of the original by Baker Chiropractic & Acupuncture. I authorize release to the Health Care Financing Administration and its agents any information needed to determine these benefits are payable.

I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.

When I pay by check, I expressly authorize this provider, if my check is dishonored or returned for any reason, to debit my account for the amount of the check plus a processing fee of \$25.00 plus any applicable sales tax. The use of a check for payment is my acknowledgment and acceptance of this policy and its terms.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I also understand and agree that all services rendered me are charged directly to me and services rendered me will be immediately due and payable. I further agree and understand that if the need arises, accounts delinquent by 90 days may be placed into legal collection agency. I understand and agree that I am responsible for all court cost, collection agency fee, filing fees and attorney fees that are incurred to collect my debt.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Witnessed by:

\_\_\_\_\_  
Patient/Guardian's Signature-if applicable