

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ___ / ___ / ___

PATIENT INFORMATION

Name: (First MI Last) _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Social Security #: _____

Home: _____ Mobile: _____ Work: _____

Email: _____

Preferred Method of Contact: Text Email Phone - Home, Mobile, or Work Other: _____

*Referred By: (Name) _____

Family Friend Co-Worker Doctor Other: _____

Race & Ethnicity: (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Decline

Preferred Language:

- English
- Spanish
- Other: _____
- Decline

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____

Primary Care Physician: _____

Home: _____ Mobile: _____

Doctor's Phone: _____

Relationship:

Child Parent Spouse Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

No Auto Work Other: _____

Where would you like statements sent?

Self Other (Details below)

Will we be working with insurance? No Yes (Details)

Name: _____

Primary: _____ ID#: _____

Address: _____

Secondary: _____ ID#: _____

Phone: _____ Email: _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

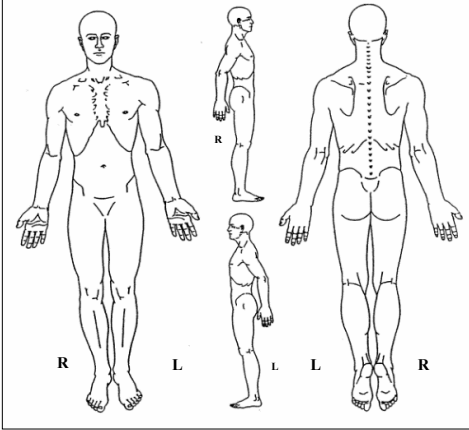
Major Complaint: _____ Secondary Complaints: _____

When did it start? ___/___/___ What happened? _____

Which daily activities are being affected by this condition? _____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

Frequency:

- Off & On
- Constant

Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: _____

Does it radiate?

- No Yes (Please indicate on drawing)

Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: _____
- Other: _____

Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: _____

Previous Treatment:

- None
- Chiropractor _____
- Medical Doctor _____
- Physical Therapy _____
- ER/Urgent Care _____
- Orthopedic _____
- Other: _____

Previous Diagnostic Testing:

- None
- X-rays _____
- MRI _____
- CT _____
- Other: _____

*Women: Are you pregnant?

- No Last Menstrual Period: ___/___/___
- Yes Due date: ___/___/___

Present Illness Comments:

Prescription Medications & Supplements: None

Yes (List - Name, dosage, frequency) _____

Allergies to Medications: No known drug allergies

Yes (List - Name and reaction) _____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you **ever** had any of the following? (Please select all that apply and use comments to elaborate.)

Illnesses:

- Asthma
- Autoimmune Disorder (Type) _____
- Blood Clots
- Cancer (Type) _____
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: _____

Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: _____

Hospitalizations: (Non-surgical with Date)

Surgeries: (If yes, provide type & surgery date)

- Cancer _____
- Orthopedic
 - Shoulder – R / L _____
 - Elbow/Forearm – R / L _____
 - Wrist/Hand – R / L _____
 - Hip – R / L _____
 - Knee – R / L _____
 - Ankle/Foot – R / L _____
- Spinal Surgery
 - Neck: _____
 - Back: _____
- Other: _____

Medical History Comments:

FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: Single Married Divorced Other

Children: None 1 2 3 4 Other: _____

Student Status: Full Student Part Student Non-Student

Highest level of Education: High School College Grad.

Post Grad. Other: _____

Employed: No Yes (Occupation) _____

Dominant Hand: Right Left Ambidextrous

Smoking/Tobacco Use: If current smoker, amount = _____

- Every Day Some Days Former Never

Alcohol Use:

- Every Day Weekly Occasionally Never

Caffeine Use:

- Coffee Tea Energy Drinks Soda Never

Exercise frequency:

- Daily 3-4xs/week 2-3xs/week Rarely Never

Social History Comments: _____

Today's Date: _____ Patient Name: _____ Account No: _____

Pain Scale

Grade Intensity/Severity (No complaint/pain) **0 1 2 3 4 5 6 7 8 9 10** (Worst possible pain/complaint imaginable)

Functional Rating Index

For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0- No Pain	1- Mild Pain	2- Moderate Pain	3- Severe Pain	4- Worst Possible Pain
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2. Sleeping

0- Perfect Sleep	1- Mildly Disturbed	2- Moderately Disturbed	3- Greatly Disturbed	4- Totally Disturbed Sleep
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3. Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions	1- Mild Pain; No Restrictions	2- Moderate Pain; Go Slowly	3- Moderate Pain; Some Assistance	4- Severe Pain; 100% Assistance
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4. Travel (driving, etc.)

0- No Pain on Long Trips	1- Mild Pain on Long Trips	2- Moderate Pain on Long Trips	3- Moderate Pain on Short Trips	4- Severe Pain on Short Trips
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5. Work

0- Usual Work + Extra	1- Usual Work, No Extra	2- 50% of Usual Work	3- 25% of Usual Work	4- Cannot Work
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6. Recreation

0- All Activities	1- Most Activities	2- Some Activities	3- Few Activities	4- No Activities
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7. Frequency of Pain

0- No Pain	1- Occasional (25%)	2- Intermittent (50%)	3- Frequent (75%)	4- Constant (100%)
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8. Lifting

0- No Pain with Heavy Weight	1- Increased Pain with Heavy Weight	2- Increased Pain with Moderate Weight	3- Increased Pain with Light Weight	4- Increased Pain with Any Weight
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9. Walking

0- No Pain with Any Distance	1- Increased Pain after 1 Mile	2- Increased Pain after ½ Mile	3- Increased Pain after ¼ Mile	4- Increased Pain after Any Distance
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10. Standing

0- No Pain with Any Time	1- Increased Pain after Several Hours	2- Increased Pain after 1 Hour	3- Increased Pain after ½ Hour	4- Increased Pain after Any Time
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Total _____ (/4, X10) = Functional Rating Score _____ %

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Patient Name: _____ D.O.B.: _____ Date: _____

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed manually, with a table mechanism to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____

Witness Signature: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

Hinze Chiropractic & Acupuncture, P.C.
Pinnacle C.O.P. Manual-1.0
Revised 10.01.2016

Patient Name: _____ D.O.B.: _____ Date: _____

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____

Signature of Parent or Guardian: _____