Patient Case History

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: M F Other

Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

Ethnicity: Caucasian_____ Hispanic_____ Native American_____ African American_____ Other_____

Language: English_____ Spanish_____ Chinese_____ Other_____

Primary Care Physician: _____ Clinic: _____

Do we have permission to contact your physician to co-manage your care, if necessary? ☐ No ☐ Yes

List any **Allergies**:

Animals☐ Aspirin☐ Bees☐ Chocolate☐ Dairy☐ Dust☐ Eggs☐ Latex☐ Molds☐ Penicillin☐

Ragweed/Pollen☐ Rubber☐ Seasonal Allergies☐ Shellfish☐ Soaps☐ Wheat☐ Other:_____

List any **Surgeries**:

Back☐ Hip☐ Knee☐ Foot☐ Neck☐ Shoulder☐ Elbow☐ Wrist☐ Brain/Neurologic☐ Other:_____

List **ALL Past Medical History / Conditions**:

Ankle Pain☐ Arm Pain☐ Arthritis☐ Asthma☐ Back Pain☐ Broken Bones☐ Cancer☐ Chest Pain☐

Depression☐ Diabetes☐ Dizziness☐ Elbow Pain☐ Epilepsy☐ Eye/Vision Problems☐ Fainting☐ Fatigue☐

Foot Pain☐ Genetic Spinal Condition☐ Hand Pain☐ Headaches☐ Hearing Problems☐ Hepatitis☐ Hip Pain☐

High Blood Pressure☐ HIV☐ Jaw Pain☐ Joint Stiffness☐ Knee Pain☐ Leg Pain☐ Menstrual Problems☐

Mid-Back Pain☐ Minor Heart Problem☐ Multiple Sclerosis☐ Neck Pain☐ Neurological Problems☐

Pacemaker☐ Parkinson's☐ Polio☐ Prostate Problems☐ Shoulder Pain☐ Significant Weight Change☐

Spinal Cord Injury☐ Sprain/Strain☐ Stroke/Heart Attack☐ Other:_____

List any **Medications** you are taking:

Medication name: _____ Dosage: _____

Medication name: _____ Dosage: _____

Medication name: _____ Dosage: _____

Medication name: _____ Dosage: _____

List your **Family History**:

Arthritis☐ Asthma☐ Back Pain☐ Cancer☐ Depression☐ Diabetes☐ Epilepsy☐ Genetic Spinal Condition☐

High Blood Pressure☐ Heart Problems☐ Multiple Sclerosis☐ Neurological Problems☐ Parkinson's☐ Polio☐

Prostate Problems☐ Stroke/Heart Attack☐ Other: _____

Have you had any auto or other accidents? ☐ No ☐ Yes Describe: _____

Have you ever had chiropractic care? ☐ No ☐ Yes Where: _____

When? _____ Why? _____ Were X-Rays taken? ☐ No ☐ Yes

When was your last adjustment? _____

Date of last Physical Exam? _____

Do you smoke? ☐No ☐Yes – How many per day? _____

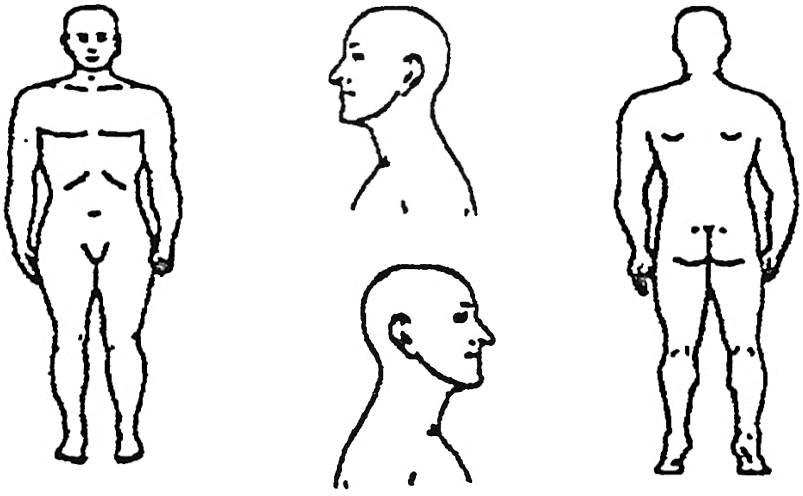
Do you drink alcohol? ☐No ☐Yes – How many per day? _____

Do you consume caffeine? ☐No ☐Yes – How many per day? _____

Do you exercise? ☐No ☐Yes – What forms & how often? _____

Answer if applicable: Are you or is there a chance you may be pregnant? ☐No ☐Yes Due Date: _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW:



What is your major complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have you had this condition in the past? ☐ No ☐ Yes

How often do you experience your symptoms?

☐Constantly (76-100% of the day) ☐Frequently (51-75% of the day)

☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐Sharp ☐Dull ☐Numb ☐Burning ☐Shooting ☐Radiating Pain

☐Aching ☐Tightness ☐Stabbing ☐Throbbing Other: _____

Please rate your pain on a scale of 1 to 10 (0 = no pain and 10 = excruciating pain)

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0 = no affect and 10 = no possible activities) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What activities aggravate your condition (working, exercise, etc.)? _____

What makes your condition better (ice, heat, massage, etc.)? _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic testing, analysis and diagnosis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever they are suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating healthcare service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Chiropractic Health, then I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

I have read and will follow all directions as stated in the policy, to the best of my ability.

Patient or Guardian Signature Date

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 our 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 form.

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 own 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 affect 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 without 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 care.

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

Patient or Guardian Signature Date

CHIROPRACTIC HEALTH

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO CHIROPRACTIC HEALTH, PRIVATE/GROUP AUTO INSURANCE OR PRIVATE/GROUP HEALTH INSURANCE

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable under my current insurance policy to **Chiropractic Health** as payment for professional services rendered:

DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay in a current manner any balance of said professional service charges over and above the insurance payment. If my current policy prohibits direct payment to the clinic or clinic doctor, then I hereby instruct and direct payment to the owner of the business, Dr. Clint Dorn, and will submit to the appropriate clinic location where services were rendered:

Chiropractic Health

Greenville Location
N1724 Municipal Drive
Greenville, WI 54942

Appleton Location
3020 E. College Ave, Suite H
Appleton, WI 54915

Oshkosh Location
1765 Taft Avenue
Oshkosh, WI 54902

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in said case.

Insured: _____ Date: _____
(Patient Signature)

Chiropractic Health Representative:

Witness: _____
(Witness Signature)

CHIROPRACTIC HEALTH

Text Message Alert Request Form

Name: _____

Date: _____

Mobile Phone Number: _____

Mobile Phone Carrier: _____

I give **Chiropractic Health** permission to send text message reminders about upcoming appointments or balance due reminders regarding my account.

Disclaimer: Message and data rates may apply. In other words, when you use our text message services, the only cost to you is whatever your wireless provider charges you to send and receive text messages. If you have an unlimited text messaging plan, there is no need to worry about additional rate charges.

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