# 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: _____

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

*Primary:* _____ *ID#:* _____

*Secondary:* _____ *ID#:* _____

**Where would you like statements sent?**

Self Other *(Details below)*

*Name:* _____

*Address:* _____

*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)*

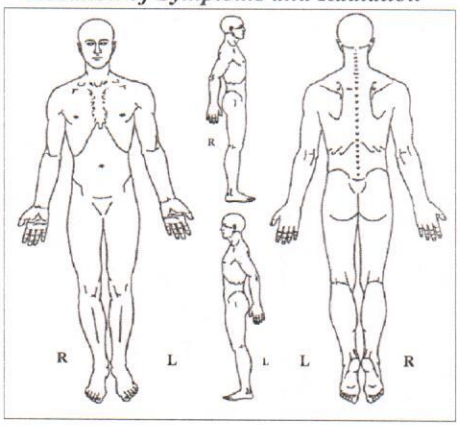
**Major Complaint:** _____ **Secondary Complaints:** _____

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

**Which daily activities are being affected by this condition?** _____

## *MAJOR COMPLAINT*

***Location of Symptoms and Radiation***




P__ Pain
N__ Numb
S__ Spasm
T__ Tender
H__ Hypoesthesia

**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:*

_____

_____

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_____

## 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:*

_____

_____

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_____

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_____

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_____

## 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:* _____

_____

_____

_____

_____

_____

_____

_____

# REVIEW OF SYSTEMS



***Many of the following conditions respond to chiropractic treatment.***

**Are you *currently* experiencing any of these symptoms?** *(Please select all that apply and use comments to elaborate.)*

**Constitutional:** *(General)*
- Fever
- Fatigue
- Other: _____
- *None in this Category*

**Musculoskeletal:**
- Joint Pain/Stiffness/Swelling
- Muscle Pain/Stiffness/Spasms
- Broken Bones_____
- Other: _____
- *None in this Category*

**Neurological:**
- Dizziness or Lightheaded
- Convulsions or Seizures
- Tremors
- Other: _____
- *None in this Category*

**Psychiatric:** *(Mind/Stress)*
- Nervousness/Anxiety
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: _____
- *None in this Category*

**Genitourinary:**
- Frequent or Painful Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Painful or Irregular Periods
- Other: _____
- *None in this Category*

**Gastrointestinal:**
- Loss of Appetite
- Blood in Stool or Black Stool
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: _____
- *None in this Category*

**Cardiovascular & Heart:**
- Chest Pains/Tightness
- Rapid or Heartbeat Changes
- Swelling of Hands, Ankles, or Feet
- Other: _____
- *None in this Category*

**Respiratory:**
- Difficulty Breathing
- Cough
- Other: _____
- *None in this Category*

**Eyes & Vision:**
- Eye Pain
- Blurred or Double Vision
- Sensitivity to Light
- Other: _____
- *None in this Category*

**Head, Ears, Nose, & Mouth/Throat:**
- Frequent or Recurrent Headaches
- Ear - Ache/Ringing/Drainage
- Hearing Loss
- Sensitivity to Loud Noises
- Sinus Problems
- Sore Throat
- Other: _____
- *None in this Category*

**Endocrine:**
- Infertility
- Recent Weight Change
- Eating Disorder
- Other: _____
- *None in this Category*

**Hematologic & Lymphatic:**
- Excessive Thirst or Urination
- Cold Extremities
- Swollen Glands
- Other: _____
- *None in this Category*

**Integumentary:** *(Skin, Nails, & Breasts)*
- Rash or Itching
- Change in Skin, Hair, or Nails
- Non-healing Sores or Lesions
- Change of Appearance of a Mole
- Breast Pain, Lump, or Discharge
- Other: _____
- *None in this Category*

**Allergic/Immunologic:**
- Food Allergies
- Environmental Allergies
- Other: _____
- *None in this Category*

*Review of Systems Comments:*

*I have answered these questions to the best of my knowledge and certify them to be true and correct.*

Patient or Guardian Signature _____ Date _____

# Runnels Chiropractic North

## Authorization and Release

I authorize payment of insurance benefits directly to Dr. Scott A Runnels or Runnels Chiropractic North LLC. I authorize Runnels Chiropractic North LLC to release any information pertinent to my case to any insurance company, adjusters, and/or attorney involved in the case, I hereby release Runnels Chiropractic North of any consequences thereof. I agree to be financially responsible for all charges incurred at Runnels Chiropractic North LLC including my insurance deductible, co-payment and any other service rejected by my insurance company. Any account unpaid after 30 days of the date of service shall bear interest at the rate of 16% per month. Should it become necessary to resort to collections, the patient shall be responsible for all costs of collections including a reasonable attorney's fee.

Insurance: Yes ____No ____Company_____

Patient's Signature: _____

Guardian's Signature: _____

## Clinical Summary Report (CCR)

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, upon request, these reports are available to be printed or emailed to me for review.

Patient Signature:_____ Date: _____

# Runnels Chiropractic North

Acknowledgement of Receipt of Notice of Privacy

## NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

Patient Name (please print):_____ Date of Birth: _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Runnels Chiropractic North LLC.

I understand that the Notice describes the uses and disclosures of my protected health information.

_____ _____

*Patient's Signature or that of Legal Representative* *Printed Name of Patient or that of Legal Representatives*

_____ _____

*Today's Date* *If Legal Representative, Indicate Relationship*

## FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could NOT be obtained because:

- Patient refused to sign
- Due to an emergency situation it was not possible to obtain an acknowledgement
- Communication barriers prohibited obtaining the acknowledgement
- Other(*please specify below)*_____

_____

_____

_____ _____

*Employee Name* *Today's Date*

# *Informed Consent to Chiropractic Treatment*

**The nature of chiropractic treatment:** Dr. Runnels will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks: I have had the following unusual risks of my case explained to me.**
**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.**

| Printed Name | Signature | Date |
|---|---|---|

**WITNESS:**

| Printed Name | Signature | Date |
|---|---|---|