Edgewood Chiropractic Center
1114 W Cook Road Fort Wayne, IN 46825
(260) 483-5588

Chiropractic Case History/Patient Information

Office use:
Date:__________ Patient # __________ Doctor:__________

NAME: ____________________ SOCIAL SECURITY #_____-_____-_____

HOME PHONE:_(____)_____-______ CELL PHONE:_(____)_____-______

ADDRESS:____________________ CITY:__________ STATE:____ ZIP:________

E-MAIL ADDRESS:________________@__________

AGE:______ BIRTHDATE:________ MARITAL STATUS: M S W D

OCCUPATION: ________________ EMPLOYER:________________

EMPLOYER'S ADDRESS:____________________ WORK PHONE: _(____)_____-______

SPOUSE'S NAME:____________ OCCUPATION:__________ EMPLOYER:__________

HOW MANY CHILDREN?_____ HOW WERE YOU REFERRED TO OUR OFFICE:____________

FAMILY MEDICAL DOCTOR:________________ When was your last physical examination?________

History of Present Illness:

CHIEF COMPLAINT (Purpose of this appointment): ________________________

DATE OF ONSET OR ACCIDENT: __________ DAYS LOST FROM WORK: __________

IS THIS DUE TO: ☐ AUTO ☐ WORK ☐ OTHER:____________________

Is this a recurrence? ☐ YES ☐ NO If so, when did you first notice the problem? ________________

How long does it last? ☐ ALL DAY ☐ FEW HOURS__________ ☐ MINUTES__________

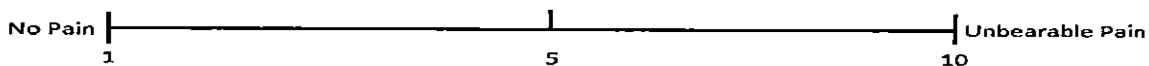
How frequent is the condition? ☐ CONSTANT ☐ DAILY ☐ INTERMITTENT ☐ NIGHT ONLY

DESCRIBE the pain: ☐ SHARP ☐ DULL ☐ NUMBNESS ☐ TINGLING ☐ ACHING ☐ BURNING ☐ STABBING ☐ OTHER:____________________

Is there anything you can do to relieve the problem? ☐ YES ☐ NO If yes, explain:________________

What makes the problem worse? ☐ STANDING ☐ SITTING ☐ LYING DOWN ☐ BENDING ☐ LIFTING ☐ COUGHING ☐ TWISTING ☐ OTHER:________________

PAIN INTENSITY: Please put line on scale describing the intensity of your pain



Have you ever had chiropractic care before? ☐ YES ☐ NO

WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Remarks:____

____

____

____

____

____

Patient Signature:____________________ Date:__________

Doctor's Signature:____________________ Date:__________

Patient Name:______________________________ Patient No:__________________

Medical History:

Please check all that apply:

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Alcoholism	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Broken/Fractured Bones	☐	☐	
Cancer	☐	☐	
Circulatory Problems	☐	☐	
Coughing Blood	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
Drug Addiction	☐	☐	
Epilepsy	☐	☐	
Excessive Bleeding	☐	☐	
Heart Disease	☐	☐	
High/Low Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Lung Disease	☐	☐	
Mental Illness	☐	☐	
Osteoarthritis	☐	☐	
Back Pain	☐	☐	
Neck Pain	☐	☐	
Seizures/Convulsions	☐	☐	
Stroke/Hypertension	☐	☐	
Ulcers	☐	☐	
Other:			
Other:			

HOSPITALIZATIONS (Please list surgeries, including childbirth): ______________________________

Have you had any major illnesses, injuries, falls or auto accidents?

____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

If yes, describe:____

Please list any CURRENT MEDICATIONS: ____

____

Social History:

Do you drink alcoholic beverages? ☐ YES ☐ NO If so, how much per week? ____________

Do you use any tobacco products? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO If so, how many packs per day? ____________

Do you take vitamin supplements? ☐ YES ☐ NO If so, please list:______________________________

Do you consume caffeine? ☐ YES ☐ NO If so, how much per day?____________

Do you exercise? ☐ YES ☐ NO If yes, what is the frequency and type of exercise?____________________

What are your hobbies?____

What percentage of time during the day (at home or at your workplace) do you spend:

Lifting? ______ Sitting? ______ Bending? ______ Working at a computer? ______

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Pain Chart

Patient's Name:______________________

Please make a slash through this line to indicate the level of your pain.

No Pain Worst Pain Possible

Draw location and type of pain on the body outline.

Pain Representation

Ache:
v v v v v v v v v

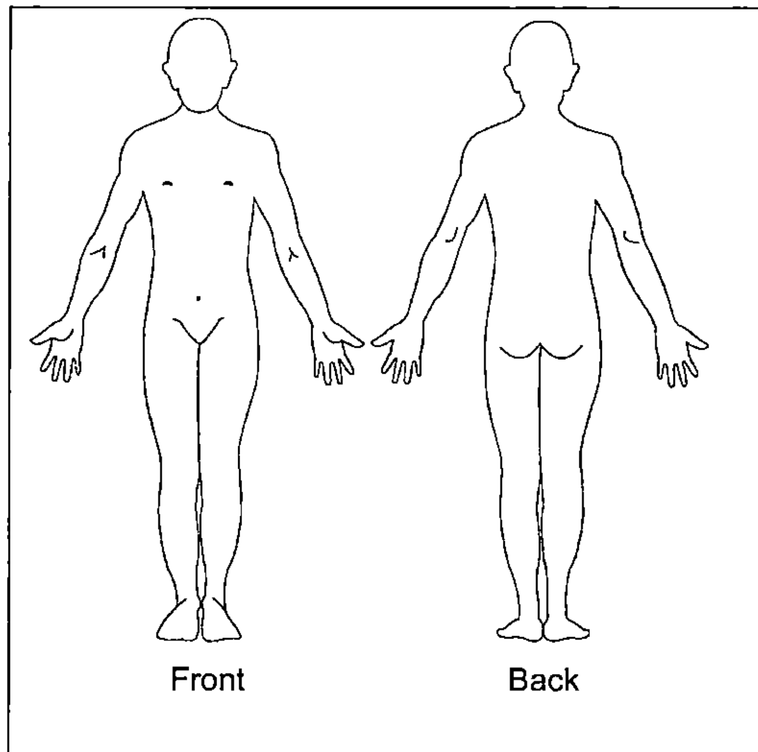
Burning:
= = = = = = = = =

Numbness:
O O O O O O O O

Pins & Needles:

Stabbing:
/ / / / / / / / /

Other:
x x x x x x x x



____

Patient's Signature Date

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HIPAA Privacy Notice

Edgewood Chiropractic Center strives to maintain the strictest confidentiality of your medical and financial information. Our employees are all aware that this information belongs to you and you have the right to decide how it is used in most instances. At this time you may request to view or receive a copy of our HIPAA policy.

To better serve you, we need you to sign and date this form acknowledging that you have read this notice and that an opportunity to review or receive a copy of our HIPAA policy has been made available to you upon request.

Financial Policy

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers. All payments are due at the time of service, unless prior arrangements have been made.

Our office accepts assignment with most insurance companies, however **insurance is not a guarantee of payment**. Your insurance is an agreement between you and your insurance company. All insurance assignment patients must pay their deductibles in full and copayment/coinsurance at time of service. If our office has not received payment by your insurance company within forty five (45) days of our office filing the claim, you will become responsible for payment in full.

I, the undersigned, do hereby agree to be financially responsible for the entire balance due, including, but not limited to, the examination, consultation, and/or treatment. I also agree to pay a service charge of $35.00 if my check is returned for insufficient funds. I understand that this service charge may be in addition to any fees assessed by my financial institution. Furthermore, I agree that a late charge of 1.5% per month may be assessed on delinquent balances. In the event of any default in payment, I agree to pay all attorney fees and/or other collection costs necessary to collect on my account.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic at Edgewood Chiropractic Center and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN AFTER YOU AGREE TO THE ABOVE

____
Printed name of Patient

x______________________________ ______________
Signature of Patient Date

x______________________________ ______________
Signature of Representative Date
(if patient is a minor or POA)

x______________________________ ______________
Witness to Patient's Signature Date

EDGEWOOD CHIROPRACTIC CENTER

Massage Scheduling, Cancellation, and No-Show Policy

Scheduling: Due to the increased demand for massages and our limited space for our Massage Therapists. We will be happy to schedule our patients one month at a time. This will give every patient an opportunity to have a convenient time that will best suit his/her schedule.

Cancellations: We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide 24-hour notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment time. With cancellations made less than 24-hour notice, we are unable to offer that time to other people.

We understand that certain unavoidable circumstances may not allow you to cancel within 24 hours resulting in a No-Show. Fees in this instance may be waived, but only with management approval. Our practice firmly believes that a good Massage Therapist/patient relationship is based upon understanding and good communication.

No Show: Patients who No-Show for his/her massage appointment, will be charged $40.00. No-show charges are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

18 and Under: Completion of this form by a parent or guardian confirms consent for patients eighteen and under to receive massages at Edgewood Chiropractic Center.

Questions about No-Show fees should be directed to the Billing Department (260) 483-5588. Please sign that you have read, understand, and agree to this Scheduling, Cancellation, and No-Show Policy.

Patient Name (Please Print) ________________________________

Patient/Representative Signature:________________________________

Date:____________________