**Natural Health Family Chiropractic**

**Case History Report Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male/Female

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

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M D W Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB of Insured:\_\_\_\_\_\_\_\_\_\_

Insured’s Identification#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Insured: Self, Spouse, Child, Other

Insured’s Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In Case of an Emergency**

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Report**

Reason for seeking care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Present Condition Due to Injury: **Y/N** If yes, at Work\_\_\_\_ Auto Accident\_\_\_\_ Other\_\_\_\_\_

Has the accident been reported? **Y/N** if yes, Employer\_\_\_ Insurance Agent\_\_\_ Other\_\_\_\_

List any other physicians that seen you for this, their diagnosis and treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had similar accidents or injuries before? **Y/N** if yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received chiropractic treatment previously? **Y/N** if yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?**Y/N**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any Medication (prescription or over the counter) you are currently take and the reasoning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List dates of any surgeries or treated conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List family medical history (health conditions, age of death and cause):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? **Y/N** Do you drink alcohol? **Y/N** Daily Weekly Special Occasions

Do you take vitamins/supplements? **Y/N** if yes please list each and the dosage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? **Y/N** if yes what forms and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major Complaint**



What is the Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the nature of your pain: **Sharp Dull Achy Numb Burning Shooting Tingling Radiating Stabbing Tightness Throbbing Other**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did the pain begin (Fall, Lifting, Etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your condition changing? **Getting Better Getting Worse Not Changing**

Have you had this in the past? **Y/N** How often do you experience these symptoms a day?

**Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)**

Please rate your pain on a scale of 1 to 10 with 0 being no pain and 10 being excruciating pain.

1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? (Lifting, sitting, walking, driving, working, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain better? (Ice, Heat, Massage, Etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your pain affect your ability to perform daily activities such as work, driving, walking? Yes/No

(0 being no effect and 10 being unable to perform) 0 1 2 3 4 5 6 7 8 9 10

List any details we may have missed that is important your wellness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark each item below for each sign or symptoms you presently have or previously had**:

**General Symptom** **Ear/Nose/Throat** **Respiratory**

\_\_Convulsions \_\_Earache \_\_Asthma

\_\_Dizziness \_\_Ear Noises \_\_Chronic Cough

\_\_Fainting \_\_Enlarged Thyroid \_\_Difficulty Breathing

\_\_Headache \_\_Frequent Colds \_\_Spitting Blood

\_\_Nervousness \_\_Hay Fever \_\_Spitting Phlegm

\_\_Numbness \_\_Nasal Blockage

\_\_Wheezing \_\_Nose Bleeds **Genitourinary**

**Muscles and Joints** \_\_Pain Behind eyes \_\_Blood In Urine

\_\_Poor Vision \_\_Frequent Urination \_\_Kidney Infection

\_\_Low Back Problems \_\_Sinusitis \_\_Painful Urination

\_\_Pain Between Shoulders \_\_Sore Throat \_\_Prostate Problems

\_\_Neck Problems \_\_Tonsillitis \_\_Loss of Bladder Control

\_\_Arm Problems **Gastrointestinal** **Skin Or Allergies**

\_\_Leg Problems \_\_Belching/Gas \_\_Bruising Easily

\_\_Swollen Joints \_\_Colon Problems \_\_Dryness

\_\_Painful Joints \_\_Boils \_\_Eczema/Rash/Dermatitis

\_\_Stiff Joints \_\_Constipation \_\_Hives

\_\_Sore Muscles \_\_Diarrhea \_\_Itching

\_\_Weak Muscles \_\_Excessive Hunger \_\_Sensitive Skin

\_\_Walking Problems \_\_Excessive Thirst \_\_Allergy\_\_\_\_\_\_\_\_\_\_\_

\_\_Sprains/Strains \_\_Gall Bladder Trouble **For Women ONLY**

\_\_Broken Bones \_\_Hemorrhoids \_\_Birth Control

**Cardiovascular** \_\_Liver/Gallbladder \_\_Hormone Replacement

\_\_High Blood Pressure \_\_Nausea \_\_Cramps/Backaches

\_\_Heart Attack \_\_Abdominal Pain \_\_Excessive Flow

\_\_Pain Over Heart\_\_Ulcer \_\_Hot Flashes

\_\_Poor Circulation \_\_Poor Appetite \_\_Irregular Cycle

\_\_Heart Trouble \_\_Poor Digestion \_\_Miscarriage

\_\_Rapid Heart \_\_Vomiting \_\_Painful Periods

\_\_Slow Heart \_\_Vomiting Blood \_\_Vaginal Discharge

\_\_Strokes \_\_Black Stool \_\_Breast Pain

\_\_Swelling Ankles \_\_Bloody Stool Pregnant at this time Yes/No

\_\_Varicose Veins \_\_Weight Loss/Gain

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

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

***Natural Health Family Chiropractic “NHFC”*** is committed to providing patients with quality services while maintaining the privacy of your protected health information (PHI).

***NHFC*** may disclose your PHI for healthcare purposes. Your PHI may be disclosed without your written authorization by ***NHFC***for your care, treatment, or payment.

You have the right to review your health care records. The request must be in writing, allowing ***NHFC*** 30 days to respond.

You may request an amendment be placed in your record if you disagree with anything notated. A request does not mean edits will be made, and ***NHFC*** has the right to respond with a rebuttal statement if necessary.

You have the right to file a written complaint within 180 days if you believe your privacy rights have been violated. Privacy law prohibits ***NHFC*** from retaliating against anyone who files a complaint.

I understand that ***NHFC*** is accepting my case based on examination findings and believe the outlined treatment should produce change and improvement. However, ***NHFC***cannot guarantee improvement or that complete recovery can be made.

I further understand that in chiropractic medicine, there are risks including, but not limited to, fractures, disk injuries, strokes, dislocations, sprains/strains, reactions, and other injuries or side effects which cannot be predetermined. I do not expect ***NHFC*** to be able to anticipate and explain all risks or complications, and I wish to rely on ***NHFC*** to exercise judgment during the procedure(s), which the provider feels is in my best interest.

Patients have the right to refuse treatment but should know the consequences of refusing or failing to cooperate with the prescribed treatment. Your provider will discuss specific consequences if the patient refuses to comply with prescribed treatment.

I give my full consent to ***NHFC*** to treat me or the minor I am legally responsible for. I, being the patient or legal guardian for said minor listed below, hereby authorize ***Natural Health Family Chiropractic*** against all insurance benefits, proceeds of any settlement, judgment, or verdict which may be paid to the undersigned because of the injuries or illness for which the facility has treated me.

I further authorize any insurance company, attorney, or other 3rd party payers to pay directly to ***NHFC*** all sums of money owed for any services rendered to me or the minor whom I am responsible for by any reason of accident, illness, and any other bills that are due, and to withhold such sums from any health and accident, workers compensation and all insurance or 3rd party benefits.

Patient agrees that ***NHFC*** may deliver medical records, consultations, depositions, or court appearances, which must be paid for in full in advance, and authorizes***NHFC*** to release any information pertinent to said health care to insurance company, adjuster, attorney, or legal service bureau to facilitate collections under the terms. The patient grants ***NHFC*** full power of attorney to endorse or sign my name on checks for payment of any debt owed.

As a courtesy, ***NHFC*** will obtain a verification of applicable insurance benefits as they are quoted to us, but payors may misquote benefits, coverage, or liability. ***NHFC*** is not responsible for what a 3rd party payor or representative may tell us. Any contractual, written, verbal, or other obligations or arrangements between you and an attorney, insurance company, or 3rd party payer are between you and said person.

1. ***NHFC*** will file initial insurance claims for you.
2. Copays, deductibles, and all non-covered service charges are due the day service is rendered.
3. Patients are responsible for charges on all service(s) or product(s) that may exceed the maximum allowable or when 3rd party, or insurance carrier does not reimburse ***NHFC*** enough to meet our service costs.
4. The patient must pay **in full** any amount due within 90 days of treatment. The patient is responsible for all money owed to ***NHFC***. Such payments are not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee. It is also regardless of any attorney liens or pending settlement(s). If a 3rd party payer fails to pay said balance in full within 90 days, the patient must pay the balance. The patient is fully responsible for all money owed to this facility for treatment, products, and services rendered to the patient or minor shown below.
5. It is imperative that each patient makes it to their appointment on time. If the patient cannot make an appointment, they must give **4 hours’ notice**. If the patient fails to do so, they may be required to pay for the visit.

**PATIENT CONSENT AND SIGNATURE**

With my signature below, I acknowledge that I have read this document, including **NHFC’s** terms and conditions, credit policies, and informed consent. I fully understand and have had my questions answered to my satisfaction.

**I authorize the release of confidential communication of protected health information to be provided to the following person/persons.**

Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PH# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The **RELEASE OF INFORMATION** will remain in effect until terminated by me in writing.

**Messaging:**

Please call: My Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If unable to reach me, you may**:

Leave a detailed message: **Yes/No**

Leave a message asking me to return your call: **Yes/No**

Text message me: **Yes/No**

Email me: **Yes/No**

Print Name of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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