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):_____

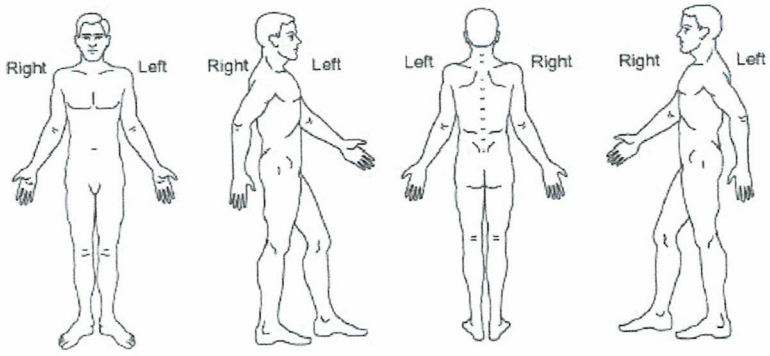
Do you smoke? **Y/N** Do you drink alcohol? **Y/N** Daily Weekly Special Occasions

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 being (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) 1 2 3 4 5 6 7 8 9 10

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

_____

_____

_____

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

General Symptom
__Convulsions
__Dizziness
__Fainting
__Headache
__Nervousness
__Numbness
__Wheezing

Muscles and Joints
__Poor Vision
__Low Back Problems
__Pain Between Shoulders
__Neck Problems
__Arm Problems
__Leg Problems
__Swollen Joints
__Painful Joints
__Stiff Joints
__Sore Muscles
__Weak Muscles
__Walking Problems
__Sprains/Strains
__Broken Bones

Cardiovascular
__High Blood Pressure
__Heart Attack
__Pain Over Heart
__Poor Circulation
__Heart Trouble
__Rapid Heart
__Slow Heart
__Strokes
__Swelling Ankles
__Varicose Veins

Ear/Nose/Throat
__Earache
__Ear Noises
__Enlarged Thyroid
__Frequent Colds
__Hay Fever
__Nasal Blockage
__Nose Bleeds
__Pain Behind eyes
__Frequent Urination
__Sinusitis
__Sore Throat
__Tonsillitis

Gastrointestinal
__Belching/Gas
__Colon Problems
__Boils
__Constipation
__Diarrhea
__Excessive Hunger
__Excessive Thirst
__Gall Bladder Trouble
__Hemorrhoids
__Liver/Gallbladder
__Nausea
__Abdominal Pain
__Ulcer
__Poor Appetite
__Poor Digestion
__Vomiting
__Vomiting Blood
__Black Stool
__Bloody Stool
__Weight Loss/Gain

Respiratory
__Asthma
__Chronic Cough
__Difficulty Breathing
__Spitting Blood
__Spitting Phlegm

Genitourinary
__Blood In Urine
__Kidney Infection
__Painful Urination
__Prostate Problems
__Loss of Bladder Control

Skin Or Allergies
__Bruising Easily
__Dryness
__Eczema/Rash/Dermatitis
__Hives
__Itching
__Sensitive Skin
__Allergy_____

For Women ONLY
__Birth Control
__Hormone Replacement
__Cramps/Backaches
__Excessive Flow
__Hot Flashes
__Irregular Cycle
__Miscarriage
__Painful Periods
__Vaginal Discharge
__Breast Pain
Pregnant at this time Yes/No

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
HIPAA Alternative Access and Financial Responsibility Form

Financial Policy: Thank you for choosing Natural Health Family Chiropractic as your Chiropractic provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we provide as pertinent information prior to treatment.

Insurance: Copayments and coinsurance are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your copay for each and every date of service along with any other chargers that is billed for your treatment. You are also responsible for your deductibles. If your insurance changes, it's **YOUR** responsibility to inform our office and we will also need copies of your new insurance cards.

Non-Covered Services: All patients are responsible if their insurance carrier denies payment for services rendered because they were "**non-covered services**". Please check with your insurance carrier prior to receiving any treatment to make sure that any of the services are covered through your insurance.

Appointments: It is very important that each patient makes it to their appointment on a timely manner. If the patient is not able to make an appointment, they are required to give a **4 hour notice** prior to their appointment time. Failure to do so will result in a **late fee charge of $25.00**.

Children Patients: The parent or guardian is responsible to be with the patient at the time of service. If the parent or guardian is not able to be present they are responsible to give consent that the chiropractor or therapist is able to see them without them being there. A verbal or written consent is required for this. Failure to do so will result in the patient not able to be seen that day.

Release of Information

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

Spouse_____ PH#_____
Child_____ PH#_____
Other_____ PH#_____
Relationship to patient_____
The **RELEASE OF INFORMATION** will remain in effect until terminated by me in writing.

Messages

Please call: My Home_____ My Cell_____
My Work_____
If unable to reach me you may: Leave a detailed message **Yes/No** Leave a message asking me to return your call **Yes/No** Do not leave a message:_____

Print Name of Patient or Responsible Party:_____ **DOB:**_____

Relationship to Patient:_____ **Date:**_____

Signature of Patient or Responsible Party:_____ **Date:**_____