BOYLE FAMILY CHIROPRACTIC

12 John St. Suite C, Kingston NY
845.943.6211

Chiropractic Case History   Today's Date:____/____/________

Full Name:_________________________________ **What you prefer to be called:** ____________________________

Sex: M F **Gender:** ______________ **Pronouns:** _______________ **Age:** _______ **DOB:** ____/____/_______

Address: ____________________________**City:** _______________ **State:** ______ **Zipcode:** ________________

Phone: _________________________Hm Wk Cell **Alternate Phone:** ________________________ Hm Wk Cell

E-Mail: _____________________________________ **Social Security #:**___________________

Employer: _________________________ **Occupation:**___________________________ **Marital Status:** S M D W

Have you ever been to a chiropractor? ___ Yes ___ No **If yes, month/year of last visit:** _____/______

Who Can We Thank for Referring You? ____

EMERGENCY CONTACT: Name _____________________________ Phone # _________________________

1. **Primary Reasons for Seeking Care:** (Ex: Pain Relief, Gain Mobility/Flexibility, Sleep Better, Be able to do… again, etc.) **Primary Reason:** _________________________ **Secondary Reason**: ______________________________

2. **Chief Complaint:** __________________________ ____New Injury___ Old Injury___ Chronic Pain___ Well Care When did this complaint begin**?** _____________

Did your injury/condition occur during**:** ___Work___Auto Accident___Sports/Play____Routine Activity____Other

Describe initial cause of complaint? ____

Is your condition getting worse? Yes No Constant Comes and goes

Have you had this or a similar condition before? Yes / No Explain: ____

Are you presently under a doctor's care for this complaint? Yes / No Clinic/Doctors name:________________________

Please circle the quality of the complaint/pain: dull aching, sharp shooting, burning, throbbing, deep nagging, tingling/numbness

Does this complaint/pain radiate or travel (shoot) to other areas of your body? Yes / No Where? ___________________

Do you have any numbness or tingling in your body? Yes / No Where? _____________________________________

What aggravates the complaint?____

What makes the complaint better?____

Is your complaint interfering with your: Work / Sleep / Daily Routine If so, how? _______________________________

Are you taking any of the following medications?

Pain Medication:_____________ Muscle Relaxers: ___________________ Blood Thinner: _________________________

Insulin/Diabetic Medication: ______________________________ Other: ____

Are there any other health concerns you would like to address? ____

3. **Previous interventions:** (treatments, medications, surgery, or other care you've sought **for your chief complaint**)

____

4. **Past Health History**:

Previous serious medical conditions (dates): ____

Previous accidents/injury/trauma (dates): ____

Have you ever broken any bones? Which? ____

Allergies: ____

Other Medications (not listed above): ____

Conditions you are taking medications for: ____

Surgeries (dates): ____

5. **Family Health History**:

Mother: ____ Living ____ Deceased Health Issues/Cause of death ____

Father: _____ Living ____ Deceased Health Issues/Cause of death ____

Siblings: _____ Living ____ Deceased Health Issues/Cause of death ____

6. **Social and Occupational History**:

Activities required at work/job description: ____

Recreational activities: ____

Sleep hrs/night: __________Exercise hrs/week:__________Types of exercise: ______________________________________

Do you take vitamins or supplements? Yes / No If so, what? ____

Do you smoke? Yes / No # of packs/day_____ # of years ______________ Alcohol drinks/week _________

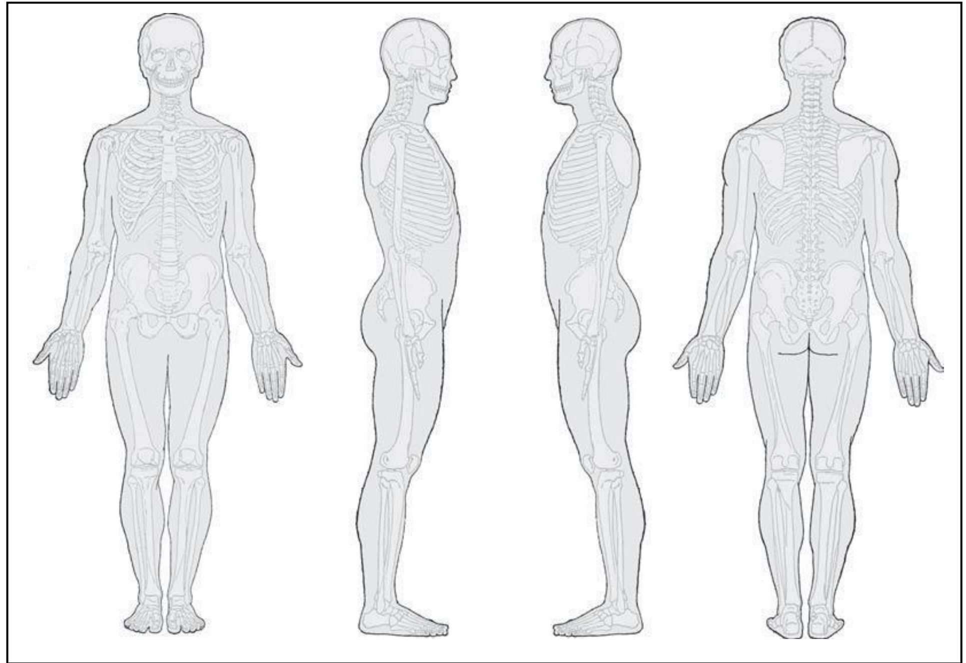
Caffeine cups/day _______________Are you wearing? Shoe Lifts_________ Arch Supports_______________

Circle the number that represents your avg. pain: (1 = discomfort, 10 = intense) 1 2 3 4 5 6 7 8 9 10

Using the pictures and symbols shown below, mark the location and type of pain you feel.

Symbols

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other__________	^ ^ ^



Please mark any of the following conditions or symptoms that you have now or have experienced:

O Severe/Freq. Headaches
Pain
O Sleeping Problems
O Low Back Pain
O Nervousness
O Tension
O Irritability
O Dizziness
O Pain between Shoulders
O Neck Stiffness
O Joint Swelling
O Fever
O Loss of Balance
O Ringing in Ears
O Jaw/TMJ Problems
O Pain in Hands or Arms

O Numbness in Hands or Arms
O Pain in Legs or Feet
O Numbness in Legs or Feet
O Fatigue
O Depression
O Lights Bother Eyes
O Loss of Memory
O Shoulder Pain
O Sinus
O Shortness of Breath
O Asthma/Emphysema
O Allergies
O Cold Hands or Feet
O HIV+/AIDS/ARC
O Chest Pains
O Heart Attack

O Stroke Neck
O Heart Attack
O High Blood Pressure
O Cancer
O Painful Urination
O Diabetes
O Diarrhea
O Constipation
O Stomach Upset
O Heartburn/Reflux
O Weight Loss
O Alcohol/Drug Abuse
O Psychiatric Problems
O Heart Surgery
O Pacemaker
O IED

FOR WOMEN ONLY:

___Birth Control__________
___Hormone Replacement
___Cramps/Backaches
___Excessive Flow
___Hot Flashes
___Irregular Cycle
___Miscarriage
___Painful Period

___Vaginal Discharge
___Breast Pain
___Menopause

Pregnant at this Time: _____Yes ____No _____Unknown
Date of Last Menstrual Period __________________
Pregnancies, Date of Deliveries, and Outcomes (list in the space provided below):

PAYMENT INFORMATION:

I understand that all payments are due to Boyle Family Chiropractic at the time services are rendered, unless prior arrangements are made. All bills are due and paid in full. All fees based upon individual services rendered and may vary from visit to visit depending upon the doctor's specific recommendations. A complete list is available at the front desk.

All payments must be made in cash, cards, or checks payable to Boyle Family Chiropractic.

INSURANCE:

We only accept:

- KTF (Magnacare)
- Blue Cross Blue Shield (Certain Plans)
- CDPHP (Certain Plans)

We **DO NOT** accept **Medicare** or **Medicaid**, even if part of the above insurance plans.

***I understand that it is my financial responsibility to pay for services that are not covered by my insurance company. Initial: ________**

HIPAA AUTHORIZATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this authorization. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices.* For the current, comprehension, up-to-date HIPPA information, you may go to healthit.gov.

Patient Name: ____

Relationship to patient (if a minor): ____

Signature: ____

Date: __________________________

TERMS OF ACCEPTANCE:

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation/adjustment are required by law to obtain your informed consent before starting treatment.

I___________________________, do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness may occur especially within the first few treatments similar to muscle soreness after exercise. Temporary dizziness and nausea may be experienced but are relatively rare. Fractures and joint injury can occur and is usually associated with underlying conditions such as physical defects, deformities, and pathologies, like weak bones from osteoporosis. When these conditions are detected, this office will proceed with extra caution.

There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely rare.

Our only practice objective is to reduce and/or eliminate musculoskeletal conditions through manual therapy; however, we may use other procedures to help your body hold the adjustments. The beneficial effects of our procedures include decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of these procedures. If this office encounters non-chiropractic findings, we will advise you and recommend the appropriate health care provider.

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

Signature_______________________________________Date _____________________

Missed, Cancelled, and Late Appointment Policies Form

If you cannot make your appointment, we require ***at least* 24 hour advanced notice**.

If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. Your consideration is appreciated because the sooner you call us the greater our chances of providing this time to someone else. Appointment times are very important to our patients as well as to us. When a patient fails to keep an appointment, this time goes unused. Even on short notice, another patient could have benefited from your appointment time. By implementing this policy, it is our goal to make as many appointments available to our patients as possible.

If a person fails to show for an appointment and/or does not provide at least 24 hour notice prior to canceling then we will charge a **fee of $50.00** for the missed appointment. **This fee must be paid in full before being scheduled for another visit.** These charges will not be billed to your insurance provider. Your appointment time is allotted to you, so we will charge you for failure to call. A message left on our answering machine or text message during or after office hours is fine, as long as it is left at least 24 hours prior to your scheduled visit.

This policy applies to the following missed appointments:

The individual was **previously informed** of this policy.
The cancellation was **not** due to a **medical emergency**.
The individual **failed to cancel** with at least **24 hours notice**.

Late Appointment Arrivals

We ask for you to plan to arrive on time for your appointment. We operate on a schedule, and try our best to keep patients from having to wait. If you arrive **more than 7 minutes late** for your appointment, we may choose to reschedule your appointment and charge you the **$50.00** missed appointment fee. If we choose to see you, your appointment time may be reduced and you will still be responsible for the full fee.

Multiple "no shows" may result in being discharged from this office or prepayment for each appointment.

We also recognize that life isn't perfect and that there are circumstances that are out of your control (sudden illness, family emergency, etc.) and so we may make an exception to the above policies in those rare occasions.

Preferred method for reminders: (circle one) Phone Call / E-mail / Text
Best Phone # / E – Mail address: ____

Thank you for your cooperation in helping us to provide the best care possible!

Print Name: ____

Signature: ____ Date: ____________