CHIROPRACTIC CASE HISTORY

Date ______________ Name ____ Sex M__ F__ Marital Status: S M D (other)

Address ____________________________________ City _____________________ State _________ Zip ________________

H.Phone (____) ________________ Cell (____) __________________ Email ______________________________________

Date of Birth ______________ Age __________ Referred by ____

Occupation ____________________ Employer ___________________________ Employer Phone _____________________

In Case of Emergency: (____) ____________ Name: ________________________ Relationship ________________________

Have you ever received Chiropractic Care? Yes No If yes when? ____

1. Primary reasons for seeking chiropractic care:

Primary Reason: ________________________________ Secondary Reason ____

Location of Complaint: _____________________________ Complaint began when and how: ______________________________

The above condition(s) are due to Auto Accident YES NO or Work Related Injury YES NO

Does this complaint/pain radiate or travel (shoot) to any areas of your body? YES NO Where? _____________

Do you have any numbness/tingling in your body? YES NO Where? ___________________________________

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

a). **How frequent is complaint present, how long does it last?**

____

b). **Does anything aggravate the complaint?**

____

c). **Does anything make the complaint better?**

____

d). **Do you have flat-feet, or pain in your feet?** _______________

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

____

____

3. Past Health History:

Previous illnesses you've had in your life:____

Previous injury or trauma____

Allergies:____

D. Medications/Vitamins You Are Currently Taking:

Medication(s) / Vitamin(s) :	Reason for taking
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

E. Surgeries You Have Had (Females, list pregnancies and outcomes here):

Date Type of Surgery

____

____

____

Females Only:

What was the date of the beginning of your last menstrual period? ______________ **Are you Pregnant now? YES NO**

4. Family Health History:

Associated health problems of relatives (circle):

Mother:	Cancer	Heart	Diabetes	Other_______	Father:	Cancer	Heart	Diabetes	Other______
Sibling:	Cancer	Heart	Diabetes	Other_______	Sibling:	Cancer	Heart	Diabetes	Other______

5. Social and Occupational History:

Level of Education: ( ) High School ( ) Some College ( ) College Graduate ( ) Post Graduate Studies

Job description: ____

Work schedule:____

Lifestyle/Exercise Routine (including tobacco and/or drug use, diet):

____

____

COMPREHENSIVE MEDICAL HISTORY: I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Signature______________________________Date______________________________

Review of Systems

Please Check all conditions you currently have or have had:			
General questions	**Cardiovascular**	**Kidneys & Urinary Tract**	**Musculoskeletal**
( ) Weight loss	( ) Angina	( ) Blood in urine	( ) Anemia ( ) Arthritis
( ) Weight gain	( ) Chest pain	( ) Brown urine	( ) Back pain ( ) Bursitis
( ) Change in sleep patterns	( ) Murmurs	( ) Painful urination	( ) Gout ( ) Joint aches
( ) Change in activity capacity	( ) Leg cramps	( ) Excessive thirst	( ) Neck Pain ( ) Tendinitis
	( )Ankle swelling	( ) Involuntary urination	( ) Abnormal Blood Counts
Neurological & Psychiatric	( ) Short of breath at night	( ) Urinating frequently (day)	( ) Blood clots in legs/ lungs
( ) Anxiety	( ) Cardiac catheterization	( ) Urinating frequently (night)	( ) Bone marrow biopsy
( ) Headaches	( ) Cold hands or feet	( ) Urine hesitancy	( ) Easy bleeding
( ) Depression	( ) Congenital heart defects	( ) Weak flow	( ) Easy bruising
( ) Meningitis	( ) Dizziness when standing	( ) Frequent bladder infections	( ) Joint swelling
( ) Paralysis	( )Heart attacks	( ) Kidney disease	( ) Morning stiffness
( ) Seizure	( ) Heart failure	( ) Kidney stone	( ) Muscle aches
( ) Stroke	( ) High/low blood pressure		
( ) Tingling	( ) Irregular heart rate	**Endocrine**	**Gatsrointestinal**
( ) Tremors	( ) Purple fingers or lips	( ) Diabetes	( )Diarrhea ( ) Gallstones
( ) Memory Loss	( ) Leg pain that resolves w/ rest	( ) Sickle cell	( ) Reflux ( ) Vomiting
( ) Fainting/ dizziness	( ) Heart palpitations	( ) Abnormal body hair	( ) Ulcers ( ) Indegestion
( ) Head injuries	( ) Varicose veins	( ) Changes in skin texture	( ) Hepititis ( ) Heartburn
( ) Blackouts		( ) Cold intolerance	( ) Abdominal pain
( ) Change in sensation	**Respiratory**	( ) History of Borderline Diabetes	( ) Anal fissures
( ) Localized weakness/ numbness	( ) Pleurisy	( ) Increased loss of hair	( ) Black tarry stools
	( ) Wheezing	( ) Rheumatism	( ) Vomiting blood
Ears, Eyes, Nose, & Throat	( ) Asthma	( ) Thyroid disease	( ) Constipation
( ) Hay fever	( ) Breathlessness when lying flat		( ) Nausea
( ) Glaucoma	( ) Prolonged cough	**Males Only**	( ) Problems swallowing
( ) Polyps	( ) Coughing up blood	( ) Hernia	( ) Hiatal Hernia
( ) Allergy	( ) Emphysema	( ) Sterility	( ) Intestinal obstruction
( ) Cataracts	( ) Shortness of breath	( ) Bloody ejaculation	( ) Liver disease
( ) Goiter	( ) Tuberculosis	( ) Inability to complete intercourse	( ) Hemorrhoids
( ) Hoarseness	( ) Pneumonia	( ) Lump on testicle	( ) Red blood after bowel movements
( ) Double vision	( ) Frequent infections(bronchitis)	( ) Penile discharge	
( ) Gum problems		( ) Premature ejaculation	**Females Only**
( ) Eye problems	**Skin**	( )Problems maintaining erection	( ) D + C ( ) Hot flashes
( ) Ear infections	( ) Abscess ( ) Athletes foot	( ) Prostate disease	( ) Hernia ( ) Fibroids
( ) Glasses/ contacts	( ) Acne ( )Boils	( ) Sores/ warts on penis	( ) Abnormal bleeding between cycles
( ) Hearing loss	( ) Hives ( ) Lumps	( ) Testicular pain	( ) Abnormal pap smear
( ) Ear discharge/ pain	( ) Jaundice ( ) Dandruff	( ) Testicular swelling	( ) Bleeding after intercourse
( ) Frequent nosebleeds	( ) Oily ski ( ) Rashes		( )Complications w/ pregnancy
( ) Ringing in ears	( ) Dry skin ( ) Psoriasis	**Male & Female**	( ) PMS ( )Endometriosis
( ) Sinus infections	( ) Excessive body odor	( ) Painful sexual intercourse	( ) Heavy bleeding during cycles
( ) Swollen glands	( ) Excessive sweatind	( ) Loss of sexual interest	( ) Discharge from breast
	( ) Fungal infections	( ) Unprotected sex	( )Ovarian cyst
	( ) Nail problems	( )Groin itching	( )Pelvic Inflamm. Disease
	( )Moles: irregular new/change	( ) Sexually transmitted diseases	( )Postmenopausal symptoms
			( )Vaginal discahrge
			( )Vaginal dryness
			( )Vaginal Warts

AdjustSA
Informed Consent to Chiropractic Adjustments and Care

RCW 18.25.005 "Chiropractic" defined

(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care of treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body.

(3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which will- include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedure consistent with this chapter.

RCW 18.25.006 Definitions

(5) "Vertebral Subluxation Complex" means a functional defect or alteration of the biomechanical physiological dynamics in a joint that may cause neuronal disturbances, with or without displacement detectable by x-ray. The effects of the vertebral subluxation complex may include, but are not limited to, any of the following: Fixation, hypo mobility, per articular muscle spasm, edema, or inflammation.

(9) "Chiropractic Adjustment" means chiropractic care of a vertebral subluxation complex, articular dysfunction, or musculoskeletal disorder. Such care includes manual or mechanical adjustment of any vertebral articulation and contiguous articulations beyond the normal passive physiological range of motion.

It is not uncommon for some patients to experience some increased discomfort after an adjustment. If that happens, I agree to apply ice on the area and rest. If I am concerned about this discomfort or develop any new symptoms, I may call the office at 210-200-8500.If I am out of town or unable to contact the doctor, I may present myself to the emergency room.

As in all health care, there are some risks to treatment including but not limited to, muscle sprain/strain, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks or complications; however the doctor will do his best to explain the problem. Based on the facts and findings as presented to the doctor at the time of treatment, I agree to rely on the doctor to exercise judgment which is based on my best interest and well-being during the course of the procedures.

I have read the above consent with the doctor and/or staff as indicated by my signature. I have had the opportunity to ask questions about its content. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature____________________________________ **Date**________________________

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by **AdjustSA** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice
This office reserves the right to modify the privacy practices outlined in the Notice.

Signature
I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it. I am aware these offices DOES NOT have open therapy areas.

______________________ ______________________ __________
Name of Patient (print) **Signature of Patient** **Date**

______________________ __________ ______________________
Signature of Patient Representative **Date** **Relationship of Patient Representative**

____
Others we may release your PHI to

Carley Costner, D.C.
AdjustSA, PLLC

ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge AdjustSA's "Notice of Privacy Practices" has been provided to me.
I understand that I have the right to review Peters Chiropractic Clinic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for Peters Chiropractic is also provided on request at the front desk of the practice. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information what will occur in my treatment, payment of my bills or in performance of health care operations of AdjustSA describes my rights and AdjustSA may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.

Signature of Patient or Personal Representative | Name of Patient or Personal Representative | Date

Office Policies

Welcome to **AdjustSA, where *Helping You Reach Optimal Health* is our mission.**

There is much to learn about these important areas which lead to better health, and focusing on these areas will add life to your years.

Below are our office procedures regarding appointments / walk-in, and payments. Please take the time to read and become acquainted with them.

1. ***New Patient Care Services***:
New patient services consist of a consultation, an X-ray of the area of main complaint, an exam, and a chiropractic adjustment in or near the area of pain. To provide the best care, you are required to complete an **Intake Form.** The forms allow the doctor and staff to evaluate your chiropractic needs. X-Ray(s) is/are taken so that the doctor can determine the symptoms of pain. The doctor will provide a verbal report of the X-Ray to you as part of the consultation. After the XRay report, the doctor will perform the first adjustment(s) where appropriate to help alleviate your pain. Finally, the doctor will discuss a treatment plan to help restore and align your body toward wellness, and answer any questions.

2. ***Follow-up Patient Care Services***:
After initial consultation and depending on the gravity of the condition, you may need to follow up with the doctor. A treatment plan will involve of a number of follow up visits to correct your condition. The doctor will review your plan with you to determine what is best for you. Each patient is different, so not all treatment plans are the same. If you are released from your treatment plan, or have been away longer than 60 days without seeing the doctor, or you have a new pain condition, you will be required to complete a **New Condition Form**. Under this situation, it is possible a new X-ray will be needed of the area to determine the new cause of pain. Procedures explained above in the new patient section will apply.

3. Office Policy Regarding X-Rays
All new patients are required to have an X-Ray taken only where your pain originates. The X-Ray(s) is/are good for two years if no new incident occurs to the same area(s). If an established patient has been away longer than 1 year or has a new pain condition, an X-Ray may be required. If you wish to take additional X-Rays, additional fees will apply. If you wish to take your X-Ray to another physician, you must complete a Medical Release Form. To complete this process, we require 48 hours notice.

4. Patient Payment Policy
We require 100% payment of all charges due on each visit. We accept Cash, Debit, Visa, MasterCard, Discover, and American Express only.

5. Our Policy on Health Insurance
Health insurance is not required to be treated at AdjustSA. If you wish to submit your services to your healthcare insurance, we can provide you with a receipt for you to submit your treatment claim directly to your insurance.

6. Office Policy on Appointments & Walk-ins
In order to better serve our patients, we schedule appointments in advance. Walk-ins are welcome but patients with appointments will have first priority. If you are unable to keep your scheduled appointment, we ask that you cancel it at least 24 hours in advance. If you are running late, please contact us to let us know. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. If you do not contact us as stated above, you will be charge a **$15 missed appointment fee.** Please help us help others. Our office hours are posted on our website: www.adjustsa.com.

I have read the AdjustSA Policies and I will honor them.

Patient's Signature | Date