Chiropractic Case History

Name_____Sex M F Date_____

Marital status: ____ Single ____Married____Divorced____Widowed Spouse Name_____

Address_____City_____State_____Zip_____

Phone (____)_____W. Phone (____)_____ Date of Birth_____ Age_____

Referred by_____Social Security #_____

Occupation_____Employer_____

Emergency contact and #_____ Primary care physician_____

Have you ever received Chiropractic Care? Yes No If yes, when/whom?_____

Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

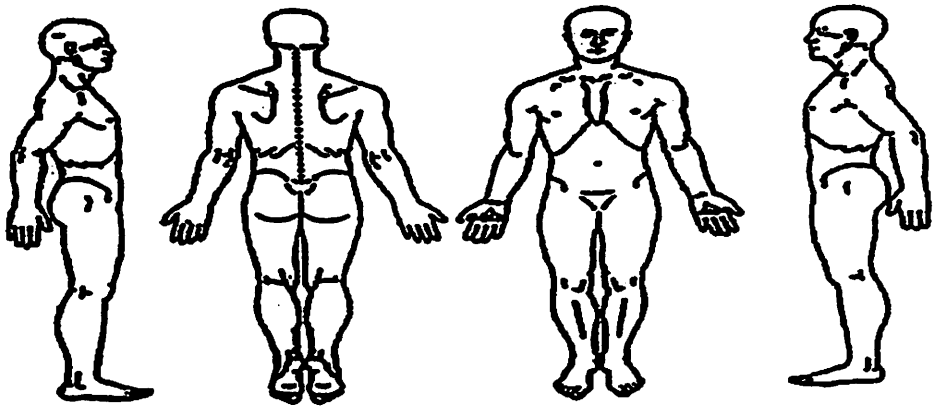
Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Please circle the Quality of the complaint/pain: dull/aching sharp shooting burning throbbing deep nagging other _____



//// Dull/Aching

^^^^ Sharp

**** Shooting

++++ Burning

0000 Throbbing

NNNN Numbness

SSSS Sensitive

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

_____

_____

_____

_____

_____

Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injuries or traumas: _____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications &/or vitamins/herbs:
Medication or type (blood pressure, cholesterol, anxiety, etc)

_____

_____

_____

E. Surgeries:
Date Type of Surgery

_____

_____

_____

F. Females/ Pregnancies and outcomes:
Pregnancies/Date of Delivery

_____

_____

Family Health History:
Associated health problems of immediate family _____

_____

Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Level of exercise: _____

C. Caffeine, Alcohol, tobacco or drug use: _____

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

Signature _____ Date _____

Parent or Guardian Signature _____ Date _____
(for minors)

NICK STOJANOVICH, D.C

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulation therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

As a part of the ANALYSIS, EXAMINATION, AND TREATMENT, *you are consenting to the following chiropractic and physical therapy procedure:*

Spinal manipulative therapy	Radiographic studies	Hot/cold therapy
Range of motion testing	Palpation	Vital signs
Muscle strength testing	Orthopedic testing	basic neurological testing
Ultrasound	Postural analysis	EMS

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocation, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care: however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability risks inherent in chiropractic adjustment

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Hospitalization
- Surgery
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow for the formation of adhesion and reduce mobility which may setup a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE INITIAL THE APPROPIATE BLOCK AND SIGN BELOW.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. Should I have any questions, I am aware that I may have my concerns answered to my satisfaction by speaking directly with Dr. Stojanovich. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date:_____

_____
Patient's Name

_____
Patient's Signature

Date:_____

Nick Stojanovich, D.C
_____

_____
Doctor's Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

DR. NICK STOJANOVICH, D.C.

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Dr. Nick Stojanovich, D.C.'s** "NOTICE OF PRIVACY PRACTICES," revision date 3-14-03.

As required by the Privacy Regulations **Dr. Nick Stojanovich, D.C.** will answer any questions that I have regarding the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **Dr. Nick Stojanovich, D.C.** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests can be made to change, restrict or object to the following by requesting the proper form:

.Alternative communication (mailing address, phone, fax, or other types of Communication).

. Restriction of my Protected health information (restrict the release of history, injury, illness, condition, diagnosis, or other information).

.Objection to any part of the "Notice of Privacy Practices."

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____ _____

Signature Date

_____

Print Name

_____

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe)_____

_____

_____

Credit Card Holder And Authorization Agreement

I, _____ authorized credit card user, give Stojanovich Chiropractic Center express authorization to charge my credit card for the purposes of

1) Payment for services rendered by Dr. Nick Stojanovich at Stojanovich Chiropractic Center.

2)Payment for goods purchased from Dr. Nick Stojanovich at Stojanovich Chiropractic Center.

3) Payment for any outstanding balance I may incur. I understand that this form constitutes a legally binding contract and that by affixing my signature to this form, I will be held responsible for all agreed upon (as stated above) charges as well as any and all collection and legal fees. This credit card is authorized

for only the charges noted above.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of all charges incurred at this office. I AUTHORIZE the release of any medical information necessary to process my insurance claims.

I Authorize payment from my insurance carrier to be paid directly to this office with the understanding that all monies will be credited to my account upon receipt. Furthermore, I undersigned hereby specifically authorized this clinic and or doctors to receive any insurance company checks in payment of the aforesaid service and to ENDORSE, DEPOSIT AND NEGOTIATE said checks in payment of undersigned's obligation to this clinic and/or Doctor.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of default, I promise to pay legal interest on the indebtedness together with such collection cost and reasonable attorney fees as by required to effect collection. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

BY MY SIGNATURE I UNDERSTAND AND AGREE TO ALL OF THE ABOVE

PATIENT SIGNATURE: _____ DATE: _____