Chiropractic Case History/Patient Information

Personal Information:

Name: _____ Social Security #_____-_____-_____Home Phone: (____)_____-_____

Address: _____City:_____ State: _____ Zip: _____

E-mail address: _____ Cell Phone: (____)_____-_____ Birth date: ____/_____/_____

Marital Status: M S W D **Occupation:**_____

Employer Name, address, phone #:_____

Race: White Black or African American Asian American Indian or Alaskan Native
Native Hawaiian or Other Pacific Islander Other Race More than One Race

What is your ethnicity? (Please Circle One) Hispanic or Latino Not Hispanic or Latino

What is your preferred language? English Spanish French German Italian
Russian Portuguese Chinese Japanese Korean Vietnamese

What is your preferred method of communication for private health data? (Please circle one)

Home Phone Work Phone Mobile Phone e-Mail Standard Mail

Spouse:_____ **Occupation**:_____ **Employer:**_____

Name of person(s) we can discuss your care/account with (name, address, phone #) _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____ If yes: Physicians name, address, phone#: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain

How many children? _____ Names and Ages of Children:_____

_____

INSURANCE INFORMATION

Please check any and all insurance coverage that may be applicable in this case**:**

___Major Medical ___Worker's Compensation ___Medicaid ___Medicare ___Auto Accident

___Medical Savings Account & Flex Plans ___Other

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (if any):_____

Insured Name _____Relationship to Insured _____

Insured ID _____ Insured Date of Birth _____ Insured Sex M F

Insured Address _____ City _____ State _____ Zip _____

Insured Phone Number _____ Insured Employer _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Patient's Signature:_____ **Date**:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Patient Health Information Consent Form - HIPAA Agreement

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

(1) **To the Patient.** This office may disclose protected health information to the patient who is the subject of the information.

(2) **Treatment, Payment, Health Care Operations.** This office may use and disclose protected health information for its own treatment, payment, and health care operations activities. We may also disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the patient and the protected health information pertains to the relationship.

(3) **Uses and Disclosures with Opportunity to Agree or Object.** Informal permission may be obtained by asking the patient outright, or by circumstances that clearly give the patient the opportunity to agree, acquiesce, or object. Where the patient is incapacitated, in an emergency situation, or not available, this office may generally make such uses and disclosures, if in the exercise of our professional judgment, the use or disclosure is determined to be in the best interests of the patient.

(4) **Incidental Use and Disclosure.** The Privacy Rule does not require that every risk of an incidental use or disclosure of protected health information be eliminated. A use or disclosure of this information that occurs as a result of, or as "incident to," an otherwise permitted use or disclosure is permitted as long as this office has adopted reasonable safeguards as required by the Privacy Rule, and the information being shared was limited to the "minimum necessary," as required by HIPAA.

(5) **Public Interest and Benefit Activities.** HIPAA permits use and disclosure of protected health information, without a patient's authorization or permission, for 12 national priority purposes. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the patient privacy interest and the public interest need for this information.

(6) **Limited Data Set.** A limited data set is defined by HIPAAA as protected health information from which certain specified direct identifiers of patients and their relatives, household members, and employers have been removed. A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature Date

Informed Consent/Treatment Authorization

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

I, the undersigned, have been informed by the participating treating Doctor of Chiropractic (D.C.) listed below, that he is a licensed chiropractor, and having been informed by such Doctor as to the benefits and potential risks of chiropractic treatment, hereby consent to such treatment.

I hereby agree to hold Dr. Bloyer and their affiliates, all associated sanctioned events and/or endorsement levels in Bloyer Chiropractic and Wellness; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands, or suits for damages from any injury or complications whatever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding and inure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complication arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Signature: _____ Date: _____

HISTORY OF PRESENT CONDITION(S)

1.) Chief Complaint(s): _____

2.) Date symptoms appeared or accident happened: _____

3.) Is this due to: Auto Work Other _____

4.) Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

_____

5.) Days lost from work: _____ Date of last physical examination: _____

6.) What does this prevent you from doing or enjoying? _____

7.) Has it become worse recently? Yes No If yes, when & how? _____

_____

8.) How frequent is the condition? Constant Daily Intermittent Night Only

9.) How long does it last? All Day Few Hours Minutes

10.) Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

11.) What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting

12.) Is there anything you have done that relieves the problem? If so, please describe: _____

_____

What have you tried that has **NOT** relieved the problem? _____

_____

13.) Are there any other conditions or symptoms that may be related to your major symptom? Yes No

If yes, describe: _____

14.) Have you ever been knocked unconscious or had the wind knocked out of you? Yes No

If so, please explain: _____

15.) Were you in any High school sports, if so list and list any injuries you sustained? _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__Ulcers
__Circulatory Problems	__Heart Disease	__Alcoholism	__Depression
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__HIV Positive
__Seizures/Epilepsy	__Ruptures	__Strokes	__Gall Bladder
__A congenital Disease	__Coughing Blood	__Cancer	__Osteoporosis
__Excessive Bleeding	__High/low blood pressure		

Have you had any major illnesses? _____

Injuries or falls? _____

Auto or work accidents? _____

Surgeries? Women, please include information about childbirth (include dates):

_____

_____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

Are you currently taking any medications? (Please circle one) **Yes** **No**

If yes, please list: _____

Are you allergic to any medications? (Please circle one) **Yes** **No**

If yes, please list: _____

Please list any other health problems you have, no matter how significant they may be: _____

_____

SOCIAL HISTORY

What is your smoking status? (Please circle one)

Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker

Do you drink alcoholic beverages? Yes No If so, how much per week? _____

Do you take vitamin supplements Yes No If so, please list: _____

Do you consume caffeine? Yes No If so, how much per day? _____

Do you exercise Yes No If so, what is the frequency and type? _____

What are your hobbies? _____

What percentage of the time during the day (at home or at work) do you spend?

Lifting_____ Sitting_____ Bending_____ Working at a computer_____

_____

Family History

Father: Living Current age: _____ Deceased Cause of death & age: _____

Mother: Living Current age: _____ Deceased Cause of death & age: _____

Are you adopted (Sometimes as an adopted child, little is known of birth parents or family). Yes No

Do you have any family members who suffer from the same condition you do?

If so, please list: _____

FAMILY DISEASES (Check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

__Tuberculosis	__Stomach Trouble	__Mental Illness	__Back Trouble	__Sinus Trouble
__Diabetes	__Asthma	__Heart Disease	__Epilepsy	__Cancer
__Stroke	__Kidney Disease	__Lung Disease	__Headaches	
__Insomnia	__Migraine	__Nervousness	__Scoliosis	
__Arthritis	__Liver Disease	__High Blood Pressure	__Other: _____	

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Back Index

Patient Name _____ ***Date***_____

This questionnaire will give your provider information about how your back condition affects your everyday life.
Please answer every section by marking the one statement that applies to you.

Pain Intensity

0 The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is very severe.
5. The pain is very severe and does not vary much.

Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal sleep is reduced by 25%.
3. Because of pain my normal sleep is reduced by 50%.
4. Because of pain my normal sleep is reduced by 75%.
5. Pain prevents me from sleeping at all.

Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases pain immediately.

Walking

0. I have no pain while walking.
1. I have some pain while walking but it doesn't increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than 1/2 mile without increasing pain.
4. I cannot walk more than 1/4 mile without increasing pain
5. I cannot walk at all without increasing pain.

Personal Care

0 I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increases the pain but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Lifting

0 I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
4. Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights.

Traveling

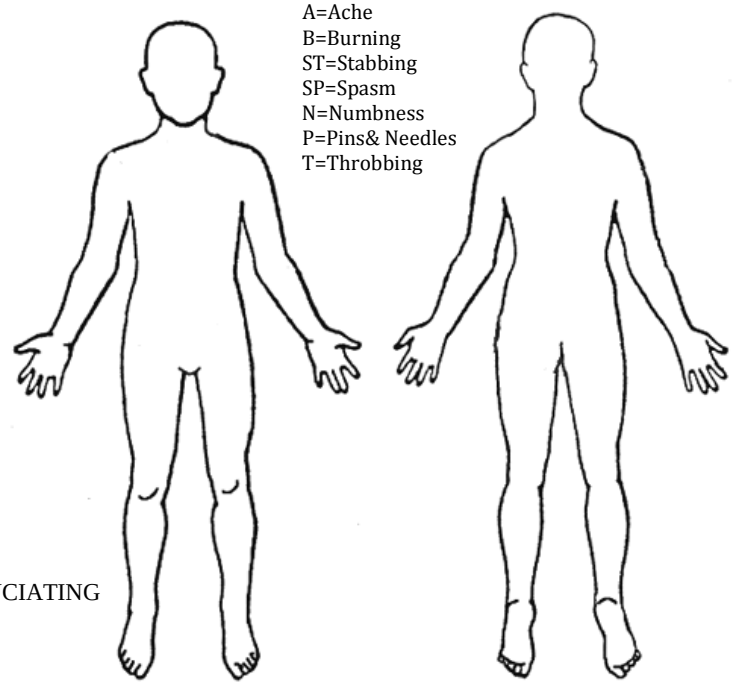
0 I get no pain while traveling.
1. I get some pain while traveling but none of my usual forms of travel make it worse.
2. I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
3. I get extra pain while traveling which causes me to seek alternate forms of travel.
4. Pain restricts all forms of travel except that done while lying down.
5. Pain restricts all forms of travel.

Social Life

0 My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Changing degree of pain

0 My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.



PAIN SCALE: Circle the number that best describes your overall pain

NONE: 0 1 2 3 4 5 6 7 8 9 10 10+ EXCRUCIATING

Signature_____ Date_____

Neck Index

Patient Name _____ ***Date***_____

This questionnaire will give your provider information about how your neck condition affects your everyday life.
Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

Sleeping

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is completely disturbed (5-7 hours sleepless).
4. My sleep is moderately disturbed (2-3 hours sleepless).
5. My sleep is greatly disturbed (3-5 hours sleepless

Reading

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I cannot read at all because of neck pain.
4. I cannot read as much as I want because of moderate neck pain.
5. I can hardly read at all because of severe neck pain

Concentration

0. I can concentrate fully when I want with no difficulty.
1. I can concentrate fully when I want with slight difficulty.
2. I have a fair degree of difficulty concentrating when I want.
3. I cannot concentrate at all.
4. I have a lot of difficulty concentrating when I want.
5. I have a great deal of difficulty concentrating when I want.

Work

0. I can do as much work as I want.
1. I can only do my usual work but no more.
2. I can only do most of my usual work but no more.
3. I cannot do any work at all.
4. I cannot do my usual work.
5. I can hardly do any work at all..

Personal Care

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

Lifting

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it cases extra pain
2 Pain prevents me from lifting heavy weights off the floor
3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on the table).
4 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift very light weights.

Driving

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight neck pain.
2. I can drive my car as long as I want with moderate neck pain.
3. I cannot drive my car at all because of neck pain.
4. I cannot drive my car as long as I want because of moderate neck pain.
5. I can hardly drive at all because of severe neck pain.

Recreation

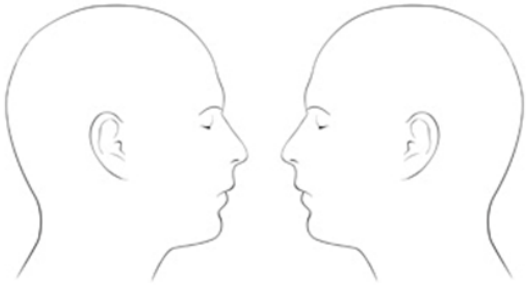
0. I am able to engage in all my recreation activities without neck pain.
1. I am able to engage in all my usual recreation activities with some neck pain.
2. I cannot do any recreation activities at all.
3. I am only able to engage in a few of my usual recreation activities because of neck pain.
4. I can hardly do any recreation activities because of neck pain.
5. I am able to engage in most but not all my usual recreation activities because of neck pain..

Headaches

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently..
5. I have headaches almost all the time

A=Ache
B=Burning
ST=Stabbing
SP=Spasm

N=Numbness
P=Pins & Needles
T=Throbbing



PAIN SCALE: Circle the number that best describes your overall pain

NONE: 0 1 2 3 4 5 6 7 8 9 10 10+ EXCRUCIATING

Signature_____ Date_____