SMITH CHIROPRACTIC OFFICES HEALTH HISTORY FORM

PERSONAL DATA

Today's Date_____

Name _____ Age _____ Date of Birth _____

Both Parent's names (if you are under 18)_____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Cell Phone (____) _____

SS#_____ E-mail address_____@ _____

Occupation _____ Employer _____

Emergency Contact (name/relation) _____ Phone _____

Marital Status: Single / Married / Divorced / Widowed Spouse's Name _____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

Please List Your Health Concerns Below

Health Concerns: (List according priority)	Rate Severity Level (1- 10) 1=Mild 10= severe	When did this episode start?	Did the problem begin with injury?	Since onset is it **B**etter **W**orse or **S**ame?	Are symptoms **C**onstant or **I**ntermittent?
1					
2					
3					
4					
5					

Have any of your complaints existed in the past? ❑ Y ❑ N If yes, describe: _____

_____

Have you had any treatment for your condition(s) outside this office? ❑ Y ❑ N If yes, list dates, treatments and doctors:

_____

Does your work or daily activities aggravate your present complaints? ❑ Y ❑ N If yes, explain:

_____

_____

What daily activities are being restricted by your current health problems? (Circle all that apply)

Carrying/Lifting	Driving	Reading/Concentration	Rising from seated position
Extended Computer Use	Standing	Sitting	Sleep
Dressing/Bathing	Climbing Stairs	Walking	Love life
Sweeping/Vacuuming	Yard Work	Exercise/Sports	Hobbies/Recreation

Since your symptoms began, have you noticed a change in the function of: ❑ Bowel ❑ Bladder ❑ Sexual ❑ No to all

If applicable describe: _____

REVIEW OF SYSTEMS: (Please indicate any **C**urrent or **P**ast conditions/illnesses)

C	P		C	P		C	P		C	P	
❑	❑	General Fatigue	❑	❑	Heat/Cold Intolerance	❑	❑	Change In Appetite	❑	❑	Painful Urination
❑	❑	Weakness	❑	❑	Sugar in urine	❑	❑	Abdominal Pain	❑	❑	Inability to Hold Urine
❑	❑	Loss of sleep	❑	❑	Diabetes	❑	❑	Hemorrhoids	❑	❑	Frequent Urination
❑	❑	Anemia	❑	❑	Tremor (shaking)	❑	❑	Ulcer	❑	❑	Urinary Retention
❑	❑	Chills	❑	❑	Thyroid Trouble	❑	❑	Excess Gas	❑	❑	Bed Wetting
❑	❑	Chronic Fever	❑	❑	Hearing Trouble	❑	❑	Vomiting	❑	❑	Kidney Trouble
❑	❑	Chronic Infections	❑	❑	Ringing in Ears	❑	❑	Diarrhea	❑	❑	Prostate Trouble
❑	❑	Night Sweats	❑	❑	Pain in Ears	❑	❑	Constipation	❑	❑	Impotence
❑	❑	Weight Change	❑	❑	Vision Trouble	❑	❑	Heartburn/Indigestion	❑	❑	Infertility/Sterility
❑	❑	Headaches	❑	❑	Pain in Eyes	❑	❑	Liver Trouble	❑	❑	Irregular/Painful Menstruation
❑	❑	Dizziness	❑	❑	Eye Discharge	❑	❑	Coughing/Wheezing	❑	❑	Breast Pain or Irregularity
❑	❑	Fainting	❑	❑	Multiple Sclerosis	❑	❑	Difficulty Breathing	❑	❑	Arthritis
❑	❑	Convulsion/Seizures	❑	❑	Nose/ Sinus Pain	❑	❑	Emphysema	❑	❑	Osteoporosis
❑	❑	Nervousness	❑	❑	Nasal/Sinus Infections	❑	❑	Asthma	❑	❑	Scoliosis
❑	❑	Anxiety	❑	❑	Nose Bleeds	❑	❑	Swollen Extremities	❑	❑	Dislocated Joints
❑	❑	Depression	❑	❑	Allergies	❑	❑	Blue Extremities	❑	❑	Spinal Disc Disease
❑	❑	Memory Loss	❑	❑	Absence of Smell	❑	❑	Varicose Veins	❑	❑	Stroke (Date:_____)
❑	❑	Mood Swing	❑	❑	Absence of Taste	❑	❑	Rapid Heartbeat	❑	❑	Aneurysm
❑	❑	Mental Condition	❑	❑	Mouth Sores	❑	❑	Chest Pain	❑	❑	Sex. Tran. Disease
❑	❑	Skin Condition	❑	❑	Gum Disease	❑	❑	Heart Condition	❑	❑	HIV / AIDS
❑	❑	Changes in Nails or Hair	❑	❑	Tonsilitis	❑	❑	High Blood Pressure	❑	❑	Cancer
❑	❑	Bruise Easily	❑	❑	Difficulty Swallowing	❑	❑	Low Blood Pressure	❑	❑	Other:_____

❑ ❑ Bone Fracture(s) (list with dates):_____

HEALTH CARE HISTORY

Have you ever had Chiropractic care? ❑Y ❑ N Name _____

Do you have a primary care physician? ❑Y ❑ N Name _____

Have you been hospitalized? ❑Y ❑ N Date(s) and Reason(s)_____

_____

Have your ever had surgery? ❑Y ❑ N Date(s) and Reason(s) _____

_____

Have you ever had a serious accident/injury? ❑Y ❑ N Date(s) and Describe injury

❑ Car / motorcycle _____ ❑ Work Related _____

❑ Personal _____ ❑ Sports Injury _____

❑ Birth Trauma _____ ❑ Abuse _____

❑ Other:_____

Are you currently taking any medications? ❑Y ❑ N

❑ Anti-inflammatory (Aspirin, Tylenol, Ibuprofen, Motrin, Aleve):_____

❑ Pain/Analgesic: _____ ❑ Anti-Depressant:_____

❑ Muscle Relaxant: _____ ❑ Blood Pressure:_____

❑ Antibiotic: _____ ❑ Birth Control:_____

❑ Corticoid Steroid: _____ ❑ Other: _____

In the past have you used any of the following: ❑ Birth Control ❑ Corticosteroid ❑ Antibiotic

Are you currently taking any vitamins, minerals, herbs or other supplements? ❑ Y ❑ N If yes, please list:

_____

Do you have any allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

_____

SOCIAL HISTORY

Smoking: ❑ Never ❑ Past ❑ Current: Packs/day _____ **Coffee:** ❑ Y ❑ N # / Day ____ **Soda:** ❑ Y ❑ N # / Day____

Alcohol: ❑ Y ❑ N Drinks / Day ____ **Recreational Drugs:** ❑ Y ❑ N substance/frequency _____

Exercise: ❑ Y ❑ N Days / Week _____ Types: ❑ Walking ❑ Jogging ❑ Cycling ❑ Swimming ❑ Strength Training ❑ Golf ❑ Tennis ❑ Cross Fit ❑ Other: _____

Water: Intake/day _____ **Diet:** How would you rate your dietary habbits? (1Terrible - 10 amazing) _____

Do you follow a special dietary regime? _____

FAMILY HISTORY (Please note any family history of listed conditions and include relationship to you.)

❑ Cancer	❑ Diabetes
❑ Osteoporosis	❑ Heart Trouble
❑ Stroke	❑ High Blood Pressure
❑ Scoliosis	❑ Anemia
❑ Genetic Disease	❑ Back/Disc Problems

FOR WOMAN

To your knowledge are you pregnant? ❑ Y ❑ N If yes, Due Date: _____ # of previous pregnancies _____

Any complications/miscarriage(s) with any prior pregnancies? ❑ Y ❑ N if yes, explain _____

Are you seeing an OBGYN regularly? ❑ Y ❑ N Name:_____ Last Exam Date: _____

OCCUPATIONAL

Job Type: ❑ Full Time ❑ Part Time [❑Retired ❑Student ❑ Unemployed] If inside [ ] skip to quality of life section

Occupation: _____ Hours/Week: _____ Days/Week: _____

Do your current complaints limit the number of hours you work per day? ❑ Y ❑ N If yes, how long? _____

How long have you been with your present employer? Years_____ Months _____

Primary work position: ❑ Seated ❑ Standing ❑ Walking ❑ Other _____

QUALITY OF LIFE (presently)

What best describes your stress level? ❑ None ❑ Minimal ❑ Min-Mod ❑ Moderate ❑ Mod-Extreme ❑ Extreme

How do you rate your physical activity at home and work? ❑ Seated > 50% of day ❑ Light ❑ Mod ❑ Heavy

How do you grade your physical health?	❑ Good	❑ Fair	❑ Poor
How do you grade your emotional/mental health?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall “quality of life”?	❑ Good	❑ Fair	❑ Poor

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

❒ OTHER_____

FINANCIAL INFORMATION

As part of the changing healthcare landscape insurance groups have been cutting reimbursement for chiropractic care. Due to this unfortunate turn of events we have chosen to function as **out of network** providers with all insurance carriers. This allows us to keep our high level of service rather than diminishing care to the level of current reimbursement.

Please indicate below the payment type you indend to use:

❑Time of Service ❑ HSA / FSA ❑ Auto Accident ❑ Workers Comp

Insurance name for auto or work comp:_____

If you have coverage, our staff will need insurance information.

Is this an Auto Accident or a Work-Related Injury? ❑ Yes ❑ No

If **yes**, please provide us with the following information:

Have you been treated elsewhere? ❑ Yes ❑ No

If **yes**, where? ❑ Emergency Room ❑ Primary Care ❑ Other _____

What services were provided? ❑ MRI ❑X-Rays ❑ Medication ❑ Therapy

❑ Other (details)_____

PLEASE READ AND SIGN

1. I acknowledge that Smith Chiropractic Offices (SCO) has informed me that they are **out of network providers** for all insuance companies. Therefore, they cannot guarantee that claims for any services rendered to me under any health insurance plan will be reimbursed.

2. **Financial Awarness:** I understand I am financially responsible, **WHETHER OR NOT MY INSURANCE COMPANY PAYS**, for all charges incurred by me. I herby assign my major medical insurance benefits, Private insurance and other insurance plans to SCO. Any overpayment will be promptly refunded. I also authorize to release any protected health information required to secure payment. Accounts over 90 days delinquent may be subject to a monthly finance charge of 1.5%, 18% annually.

3. I have been informed that a copy of SCO *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review.

4. I consent to receive communication from SCO via email, postal mail, text and telephone messaging in connection with my care.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give permission for SCO to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Name: (Printed) _____Date: _____

Signature:_____

Signature of Parent (for minor):_____ Date: _____

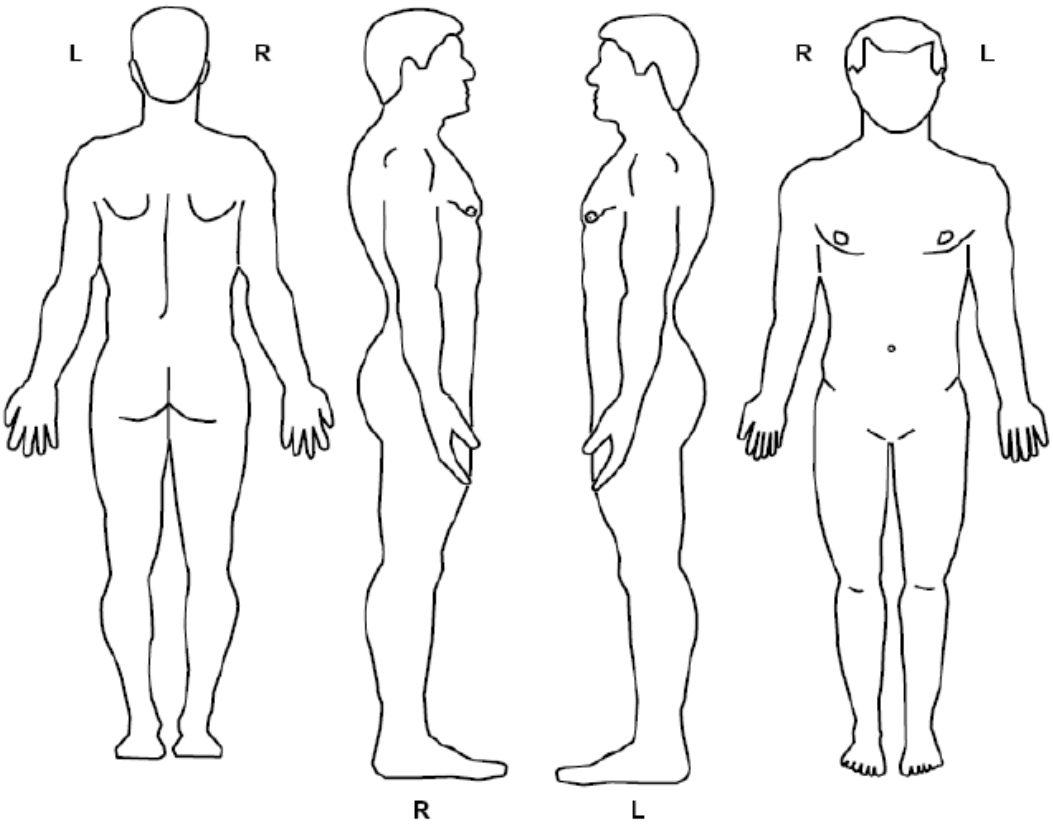
Except for sudden emergencies, please give 24 HOUR NOTICE to cancel or reschedule. YOU WILL BE BILLED FOR A MISSED APPOINTMENT (a "No Show"). Insurance companies will not pay for a missed visit.

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness (N) **Tingling (T)** **Burning Pain (B)** **Stabbing Pain (S)** **Aching Pain (A)**



VISUAL ANALOGUE SCALE

Please circle the pain level that most accurately represents your pain right now.

No pain: 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Mild Moderate Severe

Range of pain:		% of time spent in pain
Average pain:	0 1 2 3 4 5 6 7 8 9 10	_____ %
At best:	0 1 2 3 4 5 6 7 8 9 10	_____ %
At worst:	0 1 2 3 4 5 6 7 8 9 10	_____ %

= 100%

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure.

As with all types of health care interventions, there are some risks to care, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, (including but not limited to hot packs and ice), fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient name:_____ Signature: _____Date: _____

Witness name: _____ Signature: _____Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices

Pursuant to HIPAA and Consent for Use of Health Information

I, _____ [Name of Individual] consent to Smith Chiropractic Offices P.C. ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document. For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent/Guardian (circle one)