

Confidential Patient Case History

Name (*First Middle Last*) _____ SSN _____ Date _____
Address _____ City/State/Zip _____
Birth Date ___/___/___ Age ___ Spouse's Name _____ Number of Children _____
Home Phone _____ Cell Phone _____ Cell Phone Carrier _____
Email _____ Referred by _____ Preferred Contact Number: *Home Cell*
Occupation _____ *full-time part-time* Preference for Appointment Reminders: *Email Text Message*
Preferred Language: _____ Race: _____ Ethnicity: _____

Please check any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

General

- Allergies
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of Sleep
- Nervousness/depression
- Numbness

Cardio-Vascular

- Heart Disease
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor Circulation

Eyes, Ears,

Nose & Throat

- Asthma
- Colds
- Earache
- Ear noises
- Eye pain
- Failing vision
- Nosebleeds
- Sore throat
- Sinus infection

Muscle & Joint

- Arthritis
- Foot Trouble
- Low back pain
- Neck pain or stiffness
- Spinal Curvature

Pain or numbness

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Tailbone
- Sciatica

Gastro-Intestinal

- Constipation
- Diarrhea
- Difficult Digestion
- Gallbladder trouble
- Hemorrhoids
- Nausea
- Pain over stomach
- Vomiting
- Poor appetite

Respiratory

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

Genito-Urinary

- Bed Wetting
- Blood in urine
- Frequent Urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble

For Women Only

- Cramps or backache
 - Hot flashes
 - Irregular cycle
 - Menopausal symptoms
 - Painful menstruation
- Are you pregnant? Yes No

Mental Health

- Anxiety
- Depression
- Bipolar
- Other _____

Check the following conditions you have have/had

- | | | | | |
|---|-------------------------------------|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> STD |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Whooping cough |

Habits: Heavy/Moderate/Light/Never/Former

Alcohol _____ Coffee _____ Tobacco _____ Drugs _____ Exercise _____

IN CASE OF EMERGENCY: Name/Relation _____ **Phone** _____

Please complete back page.

Please Print and Complete the Following

What is your major complaint? _____

Have you had previous chiropractic care? Yes No If yes, date of last treatment _____

Is your current complaint due to the result of a motor vehicle accident? Yes No If yes, date of accident: _____

Have you been in an auto accident: Past Year Past Five Years Over Five Years Never

Is your current complaint due to the result of an injury while working on the job? Yes No If yes, date of injury _____

Have you ever been knocked unconscious? Yes No If yes, when? _____

Have you ever fractured a bone? Yes No

How long have you had this condition? _____ Have you had this or similar conditions in the past? Yes No

What activities aggravate your condition? _____

Circle any that apply: Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your Work Sleep Daily routine Other _____

Other complaints _____

List all surgical operations and years: _____

Are you currently taking any medications, vitamins, or mineral supplements? Yes No If yes, what? _____

Do you have any medication allergies? Yes No If yes, what? _____

Do you wear any of the following: Heel Lifts Arch Supports Back Brace

Have you ever had any mental or emotional disorders? Yes No If yes, when? _____

Family Health Information (Many health problems are the result of hereditary spinal weaknesses; information about your family members will give us a better picture of your total health)

Name	Relation	Past and Present Health Problems

Name of family physician _____ City _____ Phone _____

For office use only:

Height _____ Weight _____ BP ____ / ____ Pulse _____

Sunbury Chiropractic Center Financial Policy

At Sunbury Chiropractic Center, our motto is "Relief First, Wellness Always." Our recommendations for care are based on a desire to see you get well and stay well with maintenance care. Chiropractic care is covered under many insurance plans. Most of our patients have health or accident insurance that falls under one of the plans discussed in our Financial Policy brochure. Regardless of your coverage, we will suggest the chiropractic care most appropriate for your condition.

Please initial the following if applicable:

_____ I have received and read my copy of Sunbury Chiropractic's Financial Policy. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Sunbury Chiropractic Center and my insurance company. I request that Sunbury Chiropractic Center prepare the customary forms at no charge so that I can utilize my insurance benefits. I understand that I am financially responsible for any service that my insurance company may deny as not medically necessary or any other non-covered charges.

_____ I authorize SCC to release any medical information to complete any customary reports and forms to assist in collection from my insurance company. I authorize payment of medical benefits to be payable to Sunbury Chiropractic Center.

If you are not the primary policy holder:

_____ I give permission to Sunbury Chiropractic Center to speak to the guarantor on my insurance policy regarding my diagnosis, care plan, and/or financial arrangement.

Or:

_____ I do not give permission to Sunbury Chiropractic Center to speak to the guarantor on my insurance policy regarding my diagnosis, care plan, and/or financial arrangement.

SCC has permission to discuss my care and insurance with the following:

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____

Patient Parent or Legal Guardian _____

Date: _____

Sunbury Chiropractic Center X-Ray Consent

I understand that my doctor may submit my x-rays to Professional Imaging Consultants, Inc. for radiological evaluation and analysis by a Radiologist. I understand that any fee associated with this analysis will be paid for by Sunbury Chiropractic Center as a courtesy.

The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

Professional Imaging Consultants, Inc.
P.O. Box 36952
Canton, OH 44735

Patient's Signature

Today's Date

Was this injury the result of a motor vehicle accident? Yes [] No []

Did this injury occur at your place of employment? Yes [] No []

Consent for Treatment of Minor Child

I give permission to Sunbury Chiropractic Center to administer chiropractic care as deemed necessary to my child _____.

(Name of Child)

Patient Parent or Legal Guardian Signature: _____

Witnessed: _____

Date _____

PATIENT HEALTH INFORMATION CONSENT FORM

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 HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented .
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. As a way of showing our appreciation, if you refer a patient to our office, your name may be added to our referral board which is located in the patient reception area. You agree to allow this to be done or will notify us upon the referral.
9. I understand that upon entering this facility, my name will be signed on a sign-in sheet that will remain in the reception area of the office. I also realize that any person entering this office may rad my name on the sign-in sheet as a patient.

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

Name

Date