Introduction Patient Case History

Today's Date: ____/_____/_____

PATIENT INFORMATION

Name: *(First MI Last)* _____Preferred Name: _____

Address: _____City: _____State: _____Zip: _____

Date of Birth: _____ Gender: □ Male □ Female □ Other_____

Mobile: _____ Work: _____

Email: _____

Referred By: (Name) _____ Relationship: _____

(If not referred) How did you hear about us? _____

Race & Ethnicity:
□ African American or Black
□ American Indian or Alaskan Native
□ Asian
□ Hispanic or Latino
□ Native Hawaii or Other Pacific Islander
□ White
□ Decline

Preferred Language:
□ English
□ Spanish
□ French
□ Other _____
□ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ Primary Care Physician: _____

Home: _____ Mobile: _____ Doctor's Phone: _____

Relationship: _____

Is today's visit the result of an auto accident? _____

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History of Present Illness

HISTORY OF PRESENT ILLNESS (*Please describe)*

Chief Complaint: _____ Secondary Complains: _____

_____ _____

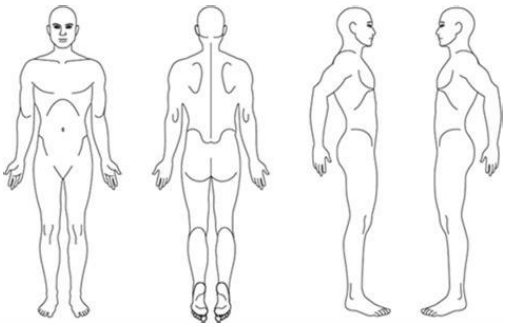
_____ _____

When did it start? _____ What Happened? _____

Which daily activities are being affected by this condition? _____

_____

CHIEF COMPLAINT



R L L R R L

P= pain N = numb S = spasm T = tender H = hypoesthesia

Grade Intensity/Severity:

□ None (0/10)
□ Mild (1-2/10)
□ Mild- Moderate (2-4/10)
□ Moderate (4-6/10)
□ Moderate-Severe (6-8/10)
□ Severe (8-10/10)

Frequency:

□ Off & On
□ Constant

Quality:

□ Sharp
□ Stabbing
□ Burning
□ Achy
□ Dull
□ Stiff & Sore
□ Other: _____

Does it radiate?

□ No □ Yes (Please indicate on drawing)

Improves with:

□ Ice
□ Heat
□ Movement
□ Stretching
□ OTC Medications: _____
_____
□ Other: _____
_____

Worsens with:

□ Sitting
□ Standing/Walking
□ Laying Down/Sleeping
□ Overuse/Lifting
□ Other: _____

Previous Treatment:

□ None
□ Chiropractor _____
□ Medical Doctor _____
□ Physical Therapist _____
□ ER/Urgent Care _____
□ Orthopedic _____
□ Other: _____

Previous Diagnostic Testing:

□ None
□ X-rays _____
□ MRI _____
□ CT _____
□ Other: _____

Women: *are you pregnant?*

□ No *Last Menstrual Period:* _____
□ Yes *Due Date:* _____

Prescription Medication & Supplements:

□ None □ Yes (*List – Name, Dosage, Frequency)* _____

_____

_____

_____

Allergies to Medications: □ No known drug allergies

□ Yes (List – Name and reaction) _____

_____

_____

_____

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IMPACT OF YOUR SYMPTOMS

How is this symptom/condition interfering with your life? (Check where appropriate)

	No Effect	*Mild Effect*	*Moderate Effect*	*Severe Effect*		*No Effect*	*Mild Effect*	*Moderate Effect*	*Severe Effect*
Work					Energy				
Exercise					Attitude				
Recreation					Patience				
Relationships					Productivity				
Sleep					Creativity				
Self-care					Other				

How committed are you to correcting this issue? **0 1 2 3 4 5 6 7 8 9 10**

Not Committed ◄——————————► Very Committed

On the arrow above:

What number do you think your health is today? _____

What direction is your health currently heading? _____

WHAT ARE YOUR HEALTH GOALS?

Immediate: _____

_____

Short term: _____

_____

Long term: _____

_____

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Past, Family and Social History

PAST MEDICAL HISTORY

Have you *ever* had any of the following? ***(Please select all that apply and use comments to elaborate.)***

Illnesses:

□ Asthma
□ Autoimmune Disorder (type)_____
□ Blood Clots
□ Cancer (type)_____
□ CVA/TIA (stroke) _____
□ Diabetes
□ Migraine Headaches
□ Osteoporosis
□ Other: _____
_____
_____

Injuries:

□ Back Injuries
□ Broken Bones
□ Head Injuries
□ Neck Injury
□ Falls
□ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____
_____
_____
_____
_____
_____

Surgeries: *(If yes, provide type & surgery date)*

□ Cancer _____
□ Orthopedic _____
Shoulder R/L _____
Elbow/Forearm R/L _____
Wrist/Hand R/L _____
Hip R/L _____
Knee R/L _____
Ankle/Foot _____
□ Spinal Surgery
Neck _____
Back _____
□ Other: _____

Medical History Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY (*Please mark X to all that apply and use comments to elaborate)*

□ Unknown □ Unremarkable

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Gender	F	M							
Age at Death (if deceased)									
Aneurysms									
CVA (stroke)									
Cancer									
Diabetes									
Heart Disease									
Hypertension									
Other Family History									

Family History Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: □ Single □ Married □ Divorced □ Other
Children: □ None or #: _____
Student Status: □ Full time □ Part time □ Non-student
Highest level of Education: □ High School □ College Grad.
□ Post Grad □ Other: _____
Employed: □ No □ Yes (occupation) _____
Dominant Hand: □ Right □ Left □ Ambidextrous
Smoking/Tobacco Use: *If current smoker, amount:* _____
Alcohol Use: □ Every day □ Weekly □ Occasionally □ Never

Caffeine Use:
□ Coffee □ Tea □ Energy Drinks □ Soda □ Never
Exercise Frequency:
□ Daily □ 3-4xs/week □ 2-3xs/week □ Rarely □ Never
Social History Comments: _____
_____
_____
_____
_____

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Review of Systems

Are you currently experiencing any of these symptoms? (*Please select all that apply and use comments to elaborate.)*

Musculoskeletal:
□ Muscle Pain/Stiffness/Spasms
□ Broken Bones_____
□ Joint pain/Stiffness/Swelling
□ Other: _____
□ *None in this category*

Eyes & Vision:
□ Eye Pain
□ Blurred or Double Vision
□ Sensitivity to Light
□ Other: _____
□ *None in this category*

Head, Ears, Nose & Mouth/Throat:
□ Frequent or Recurrent Headaches
□ Ear- Ache/Ringing/Drainage
□ Sensitivity to Loud Noises
□ Sinus Problems
□ Sore Throat
□ Other: _____
□ *None in this category*

Integumentary: *(Skin, Nails & Breasts)*
□ Non-healing Sores or Lesions
□ Rash or Itching
□ Change in Skin, Hair or Nails
□ Change of Appearance of a Mole
□ Breast Pain, Lump, or Discharge
□ Other: _____
□ *None in this category*

Neurological:
□ Dizziness or Lightheaded
□ Convulsions or Seizures
□ Tremors
□ Other: _____
□ *None in this Category*

Allergic/Immunologic:
□ Food Allergies
□ Environmental Allergies
□ Other: _____
□ *None in this category*

Psychiatric: *(Mind/Stress)*
□ Nervousness/Anxiety
□ Depression
□ Sleep Problems
□ Memory Loss or Confusion
□ Other: _____
□ *None in this category*

Hematologic & Lymphatic:
□ Excessive Thirst or Urination
□ Cold Extremities
□ Swollen Glands
□ Other: _____
□ *None in this Category*

Endocrine:
□ Infertility
□ Recent Weight Change
□ Eating Disorder
□ Other: _____
□ *None in this category*

Genitourinary:
□ Frequent or Painful Urination
□ Blood in Urine
□ Incontinence or Bed Wetting
□ Painful or Irregular Periods
□ Other: _____
□ *None in this category*

Cardiovascular & Heart:
□ Chest Pains/Tightness
□ Rapid or Heartbeat Changes
□ Swelling of Hands, Ankles or Feet
□ Other: _____
□ *None in this category*

Gastrointestinal:
□ Frequent Diarrhea
□ Constipation
□ Loss of Appetite
□ Blood in Stool or Black Stool
□ Nausea or Vomiting
□ Abdominal Pain

Constitutional:
□ Fever
□ Fatigue
□ Other: _____
□ *None in this category*

Respiratory
□ Cough
□ Difficulty Breathing
□ Other: _____
□ *None in this category*

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

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CONSENT FORM

Consent to Examination and Treatment

By signing below, I give the doctors and staff of Collective Chiropractic permission to perform all examinations, tests, treatments, and anything else deemed necessary or beneficial to my care. I also understand that by either the doctor or an assigned staff member of Collective Chiropractic will perform these actions. I further understand that all insurance payments made directly to this office will be credited to my account

Consent to Retrieve Medical Records

By signing below, I give the doctors and staff of Collective Chiropractic permission to collect any and all medical records deemed necessary to assist with my care. This includes records from hospitals or any other provider of services, which would be helpful in assisting in my case.

Consent to Release of Medical Records

By signing below, I give the doctors and staff of Collective Chiropractic permission to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge. This includes, but is not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer

Consent to Receive Appointment Reminder by text message or email

I hereby give my consent to Collective Chiropractic to send text message/ email reminders to my mobile telephone (as per the number and carrier I have listed). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to make an appointment for an adjustment. All patients have the right to stop this service. If you no longer wish to receive these text reminders, please notify our office. If you change your mobile number, please inform us so we can update our records.

Request Health Records

The patient has the right to obtain a 1-time copy of his/her health records at any time. A fee of $25 will be charged and paid in advance by the patient for forms needed to be filled out by Dr. Orr that may fall outside the normal book keeping of this office (i.e. AFLAC, FMLA, Disability, Social Security). The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of the PHI. Our office is not obligated to agree to these restrictions.

Verification of Non-pregnancy (women Only)

By my signature below, I do hereby state that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.
□ Agree □ Disagree

Assignment and Conveyance of Lien Interest for Personal Injury Patients

(Motor Vehicle Accidents Only)

I hereby execute and provide an Irrevocable Lien interest and Assignment of proceeds to apply to all monetary proceeds from any third-party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance, policy to which I am entitled, and from which I am paid in the form of any insurance settlement(s), claim(s), or verdict(s) resulting from any identified accident. The insurance carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above-named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above-named doctor and or threating facility. In the event my insurance settlement proceeds are paid directly to my attorney and I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment for all such sums directly to such named doctor and/or treating facility upon receipt of my settlements award(s). The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest rate of 15% APR after 90 days from last date of service, which is the patient's responsibility for services past rendered. Payment for services rendered at due completion of these services, unless prior written arrangement is agreed upon.

Assignment of Benefits for Insurance Purposes

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payments of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a daily basis as a courtesy to you. You will be responsible for your deductible and/ or Co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours. The patient understands and agrees to allow this chiropractic office to use the PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest rate of 15% APR after 90 days from last date of service, which is the patient's responsibility for services past rendered. Payment for services rendered at due completion of these services, unless prior written arrangement is agreed upon.

Clinical Summary Report

I understand that a clinical summary report is created after each visit for the purpose of HER and is available for my review. At this time, I am asking Collective Chiropractic to save these electronically for me and not print them out after each visit. I understand that upon request these reports are available to be printed or emailed to me for review.

Notice of Privacy Policy

By my signature below, I understand my HIPAA rights at Collective Chiropractic. Our office follows the privacy policy described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice. You can request a copy from the front desk.

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or the patient named below, for whom I am legally responsible) by Ian Orr, DC and/or other licensed doctors of chiropractic who now or in the future work at Collective Chiropractic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision. I understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains and strains. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Please read the above statements and sign below

_____ _____

Patient Name Printed Patient Signature

_____ _____

Date Parent/Guardian's Signature (for patients under 18)

DO NOT WRITE BELOW THIS LINE

Patient Accepted? YES NO Doctor's Signature_____

Collective Chiropractic