Chiropractic Case History

Name ________________________________ Sex M F Date_____________________
Address ____ State_________ Zip________
H. Phone ________________W. Phone______________ Date of Birth ____________Age_____
Email Address____ *This is our primary source of communication*
Occupation ___________________________ Employer____
Have you ever received Chiropractic Care? Yes__ No__ If yes, when?______________________________

PRIMARY REASONS FOR SEEKING CARE
Primary Reason:____
Secondary reason: ____

CHIEF COMPLAINT: Location of Complaint: ____
What was the initial cause of this complaint? ____
When did this complaint begin? ____
Are you presently under a doctor's care for this complaint? Y/N Doctors name:____________________________
Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _
Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where?
____
Do you have any numbness or tingling in your body? Where?
____
Grade Intensity/Severity (0 No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (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? ____
Does this complaint interfere with: work, home life, activities or sleep? Y/N_______________________________

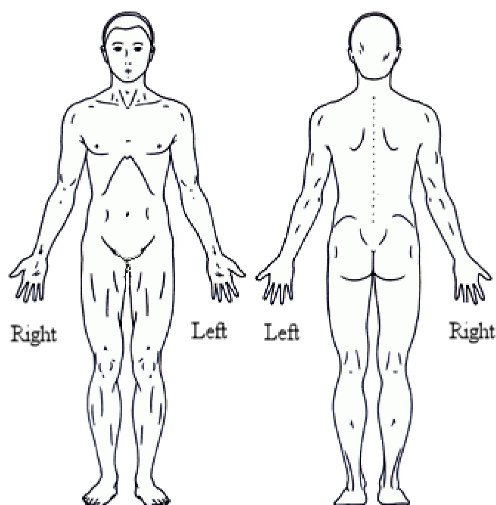
PREVIOUS INTERVENTIONS: treatments, medications, surgery, or care you've sought for your complaint
____

PAST HEALTH HISTORY:
A. Previous illnesses you've had in your life:
____
B. Previous injury or trauma:____
Have you ever broken any bones? Which?
____
C. Allergies
____
D. Medications:
____
Condition/s you are taking medications for:
____
F. Surgeries and dates:
____
G. Pregnancies, Date of Delivery & Outcomes
____
____
H. Date of the beginning of your last menstrual period?______________ Any menstrual problems?_____________________ PCOS,

FAMILY HEATLH HISTORY:
Associated health problems of relatives: ____
Deaths in immediate family:
____
Cause of parents or siblings death & age at death ____

SOCIAL AND OCCUPATIONAL HISTORY:
____
A. Level of Education:
____
B. Job description:
____
C. Recreational activities:
____
D. Do you take vitamins or supplements? Type and how often.____
E. Smoking and alcohol use. How often.____

On a scale of 1 – 10. How committed are you to resolving this complaint? __________________________________
Are there any other health concerns you would like to address?
____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ______	^ ^ ^

What activities aggravate your condition/pain?___________
What activities lessen your condition/pain?______________
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?__________
Sleep?__________Routine?_______Other?____________
Is this condition progressively getting worse?___________
____
____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _______________

FOR WOMEN ONLY
__ Birth Control __________
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient
Signature____Date__________________________

ASSIGNMENT OF BENEFITS

I authorize direct remittance of payment of all insurance benefits due to Alan Nathans Family Chiropractic (ANFC), including all General Insurance and Auto Insurance Companies. This **does not** include Medicare, as we collect the Medicare allowable amount at the time of service. This includes all covered medical services and supplies provided to me during all courses of treatment and care provided by ANFC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated or cared for by ANFC, and will constitute a continuing authorization, maintained on file with ANFC, which will authorize and allow for direct payment to ANFC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by ANFC.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or any other entity necessary to determine insurance benefits or the benefits payable for related medical services and /or supplies provided to me by Alan Nathans Family Chiropractic (ANFC). By signing this form I agree to allow ANFC to request my medical records from any/all doctors that I have seen, not limited to diagnostics, blood work and/or medical records.

____

Signature Date

HIPAA

It is the practice of this office to provide chiropractic care in a “semi open adjusting” environment. “Semi open adjusting” consists of several patients potentially being seen in the same adjusting area at the same time. Patients are within sight and “earshot” of one another, and some ongoing routine details of care are discussed. This environment is used for ongoing care, and is NOT the environment utilized for taking patient histories, performing examinations, or presenting reports of findings. We are requesting this authorization, due to various interpretations under Federal Law with respect to what is known as “incidental disclosures” of health information. It is our view that the kinds of matters related to a “semi open adjusting” environment are incidental matters. In the event that you or someone else would not agree with us, we are providing this disclosure. The use of this format is intended to make your experience in our office more efficient and productive, as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in a “semi open adjusting” environment, we can make other arrangements for you. Your decision will have no adverse effect on your care from Dr. Alan Nathans or on you relationship with our staff. Your signature indicates your authorization of this activity.

____

Printed Name Signature Date

INFORMED CONSENT

Doctor Initial	Patient Initial	
		I have been informed that it is not uncommon that patients have some increased discomfort after an adjustment. If that happens I will apply ice or heat to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the office (904-733-7393) during office hours for attention If I am out of town or unable to contact the doctor, I can present myself to an emergency room. If any tests were performed outside of this office (laboratory or other diagnostic procedures) I understand that the doctor will notify me of the results at my next scheduled appointment.
Doctor Initial	Patient Initial	I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-ray, on me by Dr. Alan Nathans and/or other doctors/therapists in this office. I have had an opportunity to discuss with Dr. Alan Nathans or personnel within the office the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but now limited to, muscle strains and sprains, disc injuries, physical therapy burns, rib injury and strokes. Strokes are the most serious complication of chiropractic treatment. The most recent studies (Journal of the FAA, Vol. 37 No. 2, June, 1993) estimate that the incidence of this type of stroke is 1 in over every 3 million upper cervical adjustments. I do not expect Dr. Alan Nathans to be able to anticipate and explain all risks and complications and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, as in my best interests.
Doctor Initial	Patient Initial	I have read the above consent, with the doctor, as indicated by our initials. 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 present condition and for any future conditions for which I seek treatment.

CANCELLATION NOTICE

We require 24 hours notice of cancellation for massage appointments. We charge a $30 fee when 24 hours notice of cancellation is not provided. This does not apply to Chiropractic appointments. Our therapists work very hard to provide you the very best care possible. We block the massage therapists time for you and appreciate your consideration. Thank You.

____

Patients Printed Name | Patients Signature | Date

____

Doctors Printed Name | Doctors Signature | Date