PATIENT CASE INFORMATION

Date: ______________ **Patient No:** ____________

Patient Information

Name: *(First MI Last)* ____ **Preferred Name:** ______________________

Address: ____ **City:** ________________ **State:** ________ **Zip:** _________________

Cell Phone: _____________________ **Cell Carrier:** ___________________ **Home Phone:** _________________________

Email Address: _____________________________________ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____________________________________ **Date of Birth:** ____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N **Where:** ______________________________

Ethnicity: Hispanic or Latina / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _______________

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoker: Everyday / Some Days / Former / Never

**** Referred By:** __________________________________ Family / Friend / Co-Worker / Doctor/ Other Source

Emergency Contact Information

Name: (First MI Last) ____________________________________ **Primary Care Physician:** _____________________________

Phone: ____ **Doctor's Phone:** ______________________________________

Relationship: Child / Parent / Spouse / Other: __________________

Insurance / Financial Information

Who is responsible for payment? Self / Other - Name: ___________________________ **Relationship:** __________________________

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury / Auto ☐ Other (please explain): __________________________

Primary Insurance Name: ___________________________ **Secondary Insurance Name:** _____________________________

***** (Please supply insurance cards to office staff so that they can be copied)***

Consent to Treat, Authorization to Release & HIPPA

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation, examination, chiropractic care, diagnostic testing, and/or therapeutic services on the above, in accordance with this state's statutes. By signing below, you consent to the taking of x-rays if there is a determined medical necessity. By signing below, you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below, you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below, I authorize the release of my x-rays to Stiles Radiology Consultants for over-read report of my x-rays if x-rays are performed.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully financially responsible for all services rendered. By signing below, you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some, or all the fees charged to your account. I further understand any disputes on coverage are between my insurance carrier and myself and that I will be responsible for payment for any denied services regardless of the outcome of my dispute. By signing below, you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below, you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT: By signing below you have acknowledged that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below, you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Signature of Patient: _______________________ ***Signature of Parent or Guardian:*** _____________________ ***Date:*** ___________

COMPLAINT INFORMATION

Date:______________ **Patient Name: (First MI Last)** ________________________________ **Patient No:** ____________

History of Current Condition

Major Complaint: ____

Secondary Complaint: ____

Date of onset: ___ / ___ / ___ **and How this began?**____

____

____

Intensity of Pain/Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

How frequent is the complaint? Off & On / Constant

Does the complaint radiate? No / Yes (Describe) __________________

Head - Base of Skull / Forehead / Temple L / R / Both Leg - Hip / Thigh-Knee / Calf / Toes L / R / B

Arm - Across Shoulder / Elbow / Hand-Fingers L / R / Both Other Area: ______________________________

What makes it Better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: ____

What makes it Worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: ____

Which daily activities are being affected? (*Describe*) ____

For this condition, have you:

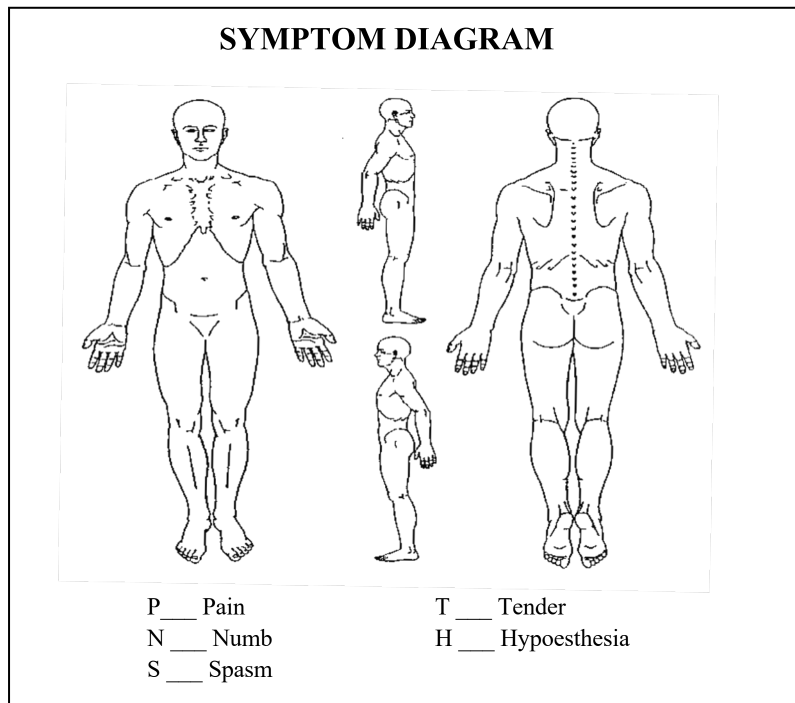
Other Treatment? None / DC / MD / PT / Massage / Other: __________________ Where: ________________________________

Other Diagnostic Testing? X-rays / MRI / CT / Other: ______________________ Where: ________________________________

*__Women:__ ***Are you pregnant? Yes / No*** *Last menstrual period:* ___ / ___ / ___ *Due Date:* ___ / ___ / ___

Pain/Complaint Diagram

SYMPTOM DIAGRAM



P___ Pain T ___ Tender
N ___ Numb H ___ Hypoesthesia
S ___ Spasm

Patient Signature: ____ ***Physician's Initials:*** ____________

REVIEW OF SYSTEMS

Date:______________ **Patient Name: (First MI Last)** ___________________________________ **Patient No:** _____________

Review of Systems

General:
- ☐ Weight Change
- ☐ Fatigue
- ☐ None

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Other: _______________
- ☐ None

Neurological:
- ☐ Numbness
- ☐ Loss of Feeling
- ☐ Dizziness
- ☐ Headaches
- ☐ Other: _______________
- ☐ None

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Loss of Memory
- ☐ Other: _______________
- ☐ None

Genitourinary:
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Bed Wetting
- ☐ Other: _______________
- ☐ None

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Change of Bowel
- ☐ Painful Bowel
- ☐ Nausea Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Other: _______________
- ☐ None

Heart:
- ☐ Rapid Heartbeat
- ☐ Blood Pressure Prob.
- ☐ Swelling hands/ankles
- ☐ Other: _______________
- ☐ None

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Asthma
- ☐ Lung Problems
- ☐ Other: _______________
- ☐ None

Eyes and Vision:
- ☐ Wear Glasses/Contacts
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Other: _______________
- ☐ None

Ears, Nose & Throat:
- ☐ Swollen glands in neck
- ☐ Ringing in ears
- ☐ Ear Ache
- ☐ Sinus Problems
- ☐ Hearing Loss
- ☐ Other: _______________
- ☐ None

Endocrine & Lymphatic:
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Cold Extremities
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Other: _______________
- ☐ None

Women:
- ☐ Infertility
- ☐ Irregular periods
- ☐ None

Health History

Medications and Supplements:

Allergies to Medications: ☐ **NONE**

Name	Reaction

Current Medications & Supplements: ☐ **NONE**

Name	Dosage

Past Health History:

Surgeries: ☐ **NONE**

Date	Describe

Major Injuries / Traumas / Hospitalizations / Cancer / Stroke :

☐ **NONE**

Date	Describe

Family Health History: ☐ **NONE**

List major health problems of 1st degree relatives:

Problem	Relation (Parent, Sibling, Child)

Social and Occupational History:

Smoking: ☐ Every Day ☐ Some Days ☐ Former ☐Never

Habit	Type / Amount / Year Started
Smoking	
Tobacco	
Alcohol	
Caffeine	
Rec. Drugs	

Additional Comments:

____

____

____

____