INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____ **Patient No:** _____ (*For office use only*)

PATIENT INFORMATION

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

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mobile: _____**Mobile Carrier:** _____**Home:**_____ **Work:** _____

Social Security #:_____**Date of Birth:** _____-_____-_____ **Age:** _____ **Gender:** M/F

Email: _____

Spouse:_____ **N/A**

Children & Ages:_____

Employed?

- ❑ **Yes -- Employer** _____
- ❑ **No**

Preferred method of communication for patient reminders: (Circle one): Email / Phone / Mail

***Who referred you to our office?**_____

Student Status: Non-Student / Full Student / Part Student

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Other

Preferred Language: English / Spanish / Other_____

Race: Asian / African Am / Am. Indian or Alaskan Native / White / Native Hawaii or Pacific Island / Other

Smoking Status: Every Day / Some Days / Former / Never

Date Started_____ **Date Ended**_____

EMERGENCY CONTACT

Full Name: _____

Home: _____ **Mobile:** _____

Relationship: Child / Parent / Spouse / Other**:** _____

Primary Care Physician: _____

Doctor's Phone: _____

FINANCIAL INFORMATION

❑ Insurance ❑ Worker's Comp ❑ Self Pay (cash) ❑ Personal Injury / Auto ❑ Other (please explain)_____

***Primary Insurance (or present card to front desk)**

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

(If other than self):

Insured's Name:_____ **Gender:** M/F

Address: _____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **Date of Birth:**____-____-____

***Secondary Insurance**

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

(If other than self):

Insured's Name:_____ **Gender:** M/F

Address: _____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **Date of Birth:**____-____-____

Who is responsible for payment: Self / Other – *(Relationship)* _____

Other than self:

Full Name: _____**Phone:** _____

Address:_____**City:**_____ **State:**_____ **Zip:** _____

It is Usual and Customary to Pay for Services as Rendered, Unless Otherwise Arranged

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____/_____/_____ Describe how this began:_____

_____

_____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other**:** _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)*_____

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

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other**:**_____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities (i.e. work) are being affected by this condition? (*Describe):*_____

For this CURRENT condition, have you:

• **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other**:** _____ **Where?**_____

• **Had any previous Surgery or Interventions in this area?** *(Describe)*_____

• **Taken any Medications?** OTC / Prescriptions *(list)* _____

• **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

HEALTH HISTORY *(please see reverse side of this page for additional space)*

Medications:

Allergies to Medications: ***NONE*** *(list)* _____

_____

Reaction: _____

Current Medications & Dosage: ***NONE*** *(list)*

_____

_____

_____

Past Health History: *(List)*

Surgeries – Date, Type, and Reason: ***NONE***

_____

_____

_____

Major Injuries/Traumas: ***NONE***_____

_____

_____

Major Hospitalizations: ***NONE*** _____

Family Health History: *(Mark N/A if not relevant.)*

List *relevant* major family health problems:

_____

_____

_____

Deaths in immediate family: *(Cause and Age)*

_____

_____

***Social and Occupational History*:**

Level of Education Completed:

High School / Some College / College Grad / Post Grad / other

Lifestyle: *(Hobbies, Activities, Exercise, Diet, Work, Vitamins)*

Habits:

Cigarettes- *(#/day)* _____

Alcohol- *(amount/day)*_____

Coffee/Tea – *(cups/day)*_____

Rec. Drugs – *(List)*_____

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ❑ Recent weight change
- ❑ Fever
- ❑ Fatigue
- ❑ *None in this category*

Musculoskeletal:
- ❑ Low back pain
- ❑ Mid-back pain
- ❑ Neck pain
- ❑ Arm problems _____
- ❑ Leg problems_____
- ❑ Painful joints
- ❑ Stiff/swollen joints
- ❑ Sore/weak muscles or joints
- ❑ Muscle spasms/cramps
- ❑ Broken bones
- ❑ Other: _____
- ❑ *None in this category*

Neurological:
- ❑ Numbness or tingling sensations
- ❑ Loss of feeling
- ❑ Dizziness or light headed
- ❑ Frequent or recurrent headaches
- ❑ Convulsions or seizures
- ❑ Tremors
- ❑ Stroke
- ❑ Head injury
- ❑ Ever been in an auto accident?
- ❑ Other: _____
- ❑ *None in this category*

Mind/Stress:
- ❑ Nervousness
- ❑ Depression
- ❑ Sleep Problems
- ❑ Memory loss or confusion
- ❑ Other: _____
- ❑ *None in this category*

Genitourinary:
- ❑ Sexual difficulty
- ❑ Kidney stones
- ❑ Burning/painful urination
- ❑ Change in force/strain w/urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Incontinence or bed wetting
- ❑ Other: _____
- ❑ *None in this category*

Gastrointestinal:
- ❑Loss of appetite
- ❑ Blood in stool
- ❑ Change in bowel movements
- ❑ Painful bowel movements
- ❑ Nausea or vomiting
- ❑ Abdominal pain
- ❑ Frequent diarrhea
- ❑ Constipation
- ❑ Other: _____
- ❑ *None in this category*

Cardiovascular & Heart:
- ❑ Chest pains
- ❑ Rapid or heartbeat changes
- ❑ Blood pressure problems
- ❑ Swelling: hands/ankles/feet
- ❑ Heart problems
- ❑ Other: _____
- ❑ *None in this category*

Respiratory:
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Coughing blood
- ❑ Asthma or wheezing
- ❑ Lung Problems
- ❑ Other: _____
- ❑ *None in this category*

Eyes and Vision:
- ❑ Wear contacts/glasses
- ❑ Blurred or double vision
- ❑ Glaucoma
- ❑ Eye disease or injury
- ❑ Other: _____
- ❑ *None in this category*

Ears, Nose and Throat:
- ❑ Bleeding gums / mouth sores
- ❑ Bad breath or bad taste
- ❑ Dental problems
- ❑ Swollen throat or voice change
- ❑ Swollen glands in neck
- ❑ Ear Infections
- ❑ Ear – Ache / Ringing / Drainage
- ❑ Sinus / Allergy problems
- ❑ Nose Bleeds
- ❑ Hearing Loss
- ❑ Other: _____
- ❑ *None in this category*

Endocrine, Hematologic, and Lymphatic:
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Excessive thirst or urination
- ❑ Cold extremities
- ❑ Heat or cold intolerance
- ❑ Change in hat or glove size
- ❑ Dry skin
- ❑ Glandular or hormone problem
- ❑ Swollen glands
- ❑ Anemia
- ❑ Easily bruise or bleed
- ❑ Phlebitis
- ❑ Transfusion
- ❑ Immune system disorder
- ❑ Other: _____
- ❑ *None in this category*

Skin and Breasts:
- ❑ Rash or itching
- ❑ Change in skin color
- ❑ Change in hair or nails
- ❑ Non-healing sores
- ❑ Change of appearance of a mole
- ❑ Breast pain
- ❑ Breast lump
- ❑ Breast discharge
- ❑ Other: _____
- ❑ *None in this category*

Women Only:

Are you pregnant?

❑ **Yes - Due date** ____/____/_____

❑ **No -** ***Last Menstrual Period***

____/____/_____

- ❑ Infertility
- ❑ Painful or Irregular periods
- ❑ Vaginal Discharge
- ❑ Other: _____
- ❑ *None in this category*

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____Date_____

Doctor Signature _____ Date_____

INFORMED CONSENT

REGARDING: Exam, X-Rays, Chiropractic Adjustments, Therapeutic Procedures, and Insurance

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Baker Chiropractic Healthcare, P.C. have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to a full examination and treatment by any means, method, and or techniques, the doctor deems necessary to determine and treat my condition at any time throughout the entire clinical course of my care.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, minor fractures and possible stroke, which occurs at a rate between one instances per one million to one per two million.

❑ I choose to decline receipt of my clinical summary after every visit and understand I am legally inclined to receive a copy of my records at any time.

I hereby authorize payment to be made directly to Baker Chiropractic Healthcare, P.C., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Baker Chiropractic Healthcare, P.C. for any and all services I receive at this office.

_____ ____/____/____ ☐ Witness Initial

Patient or Authorized Person's Signature Date

BAKER CHIROPRACTIC HEALTHCARE, P.C. NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by statements below, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

PERMITTED DISCLOSURES:

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas mean open discussion, if you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes: To obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: To process a claim or aid in investigation.
5. Emergency: In the event of a medical emergency we may notify a family member.
6. For public health and safety: In order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement: To identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons: For discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders: We may call your home and leave messages, email or text you regarding a missed appointment or update you of changes in practice hours or upcoming events.
11. Change of ownership: In the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive detailed privacy notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information, however like restrictions we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made we will be happy to accommodate you, however you will be responsible for this cost.

I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Date

_____ _____

Witness Date