Hudson Chiropractic Wellness Center

CASE HISTORY

Name_____Age_____Date_____
Address_____City_____State____Zip_____
Home Phone_____Date of Birth_____Sex: M F Marital Status: S M D W
Social Security #_____E-Mail Address:_____
Employer_____Work Phone:_____
Insurance Company_____Phone:_____
Insured's Name_____Phone:_____
(If you are not the insured)
Insured's ID #or SS #_____
Spouse's Name_____Occupation:_____
Spouse's Insurance Co._____Work Phone:_____
Spouse's Social Security #_____
Present condition due to an injury?___ Yes___ No
If Yes was it on the Job?___ Auto Accident?___ Other:_____
Has the accident been reported?___Yes___No
If Yes to Employer?___Auto Carrier?___Other:_____
How were you referred to this office _____

HEALTH HISTORY

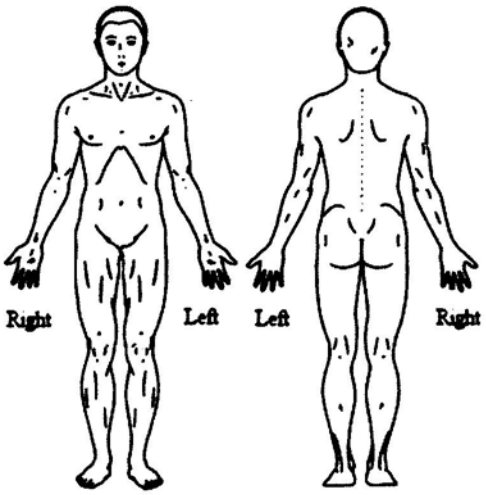
Reason for seeking care:_____
List any other doctors seen for this:_____
List any diagnosis and type of treatment:_____
Have you had similar accidents or injuries before?___Yes___No If yes, explain:_____
_____
_____
Name:_____Date___/___/___ File:_____
Have you received chiropractic treatment previously?___Yes___No
If yes, explain:_____
Have you been treated for any health condition by a physician in the last year?___Yes___No
If yes, explain:_____
Are you currently taking medication?___Yes___No list medications:_____
_____
List conditions you are taking medications for:_____
List the approximate dates of any surgery, treated conditions, or hospitalizations:_____
_____
Smoke Y/N Alcohol Y/N___Daily___Weekly___Social Events Daily #of caffeinated drinks_____

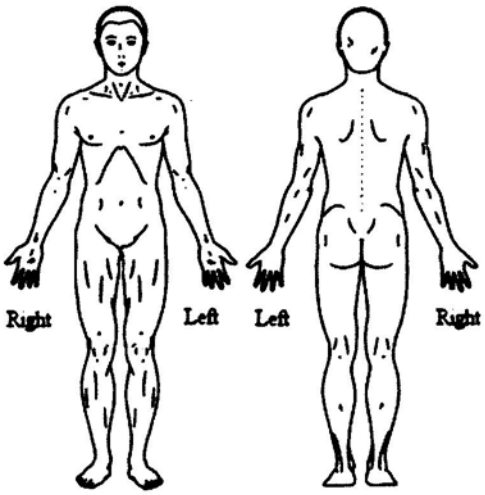
Do you take Vitamins/Supplements: Y/N If yes, type and how often_____
_____

Using the 1st letter of the symptoms listed, mark on the pictures where you feel the pain. Numbness (N), Dull Ache (D), Burning (B), Sharp/Stabbing(SS), Pins/Needles (PN)

Pain Scale 0 1 2 3 4 5 6 7 8 9 10

0-1 = No pain
2-3 = Mild pain
4-5 = Discomforting – Moderate pain
6-7 = Distressing – Severe pain
8-9 = Intense – very severe pain
10 = Unbearable pain





When did your symptoms appear?_____
How often do you have these symptoms/pain?_____
What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is the 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?_____
STRESS: Please rate your stress management strategies: Perfect 1 2 3 4 5 6 7 8 9 10 Terrible
Please rate your daily stress Level: None 1 2 3 4 5 6 7 8 9 10 Terrible
PREGNANCY: # of pregnancies_____ #Birth Children_____N/A_____

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives.

Condition Body System	SELF	GRANDPARENTS	PARENTS	SIBLING	CHILD
Aids/HIV					
Arthritis					
Bleeding Disorders					
Cancer					
Endocrine/Glandular (diabetes/thyroid)					
Hepatitis					
Immune					
Stroke/TIA					
Circulatory Problems (blood, vessels, heart)					
Ear, Nose, Throat					
Heart Problems					
High Blood Pressure					
Neurological					
Gastrointestinal (stomach, intestines)					
Muscle/Joint/Bone					
Genitourinary (urine, kidney, prostate)					
Psychological					
Respiratory (lung, breathing)					
Skin					

OFFICE POLICY

Welcome to Hudson Chiropractic Offices. Dr Hudson and the entire staff are dedicated to providing you with the finest in chiropractic health care! Please take a moment to acquaint yourself with our office policies. Our policies are designed to enhance your doctor patient relationship.

APPOINTMENTS: For your convenience, patients are seen on an appointment basis. We respect that your time is valuable too! Kindly give 24 hours advance notice, when possible if you must reschedule or cancel an appointment. If you do not call to reschedule or cancel prior to your scheduled appointment you may be billed for the scheduled treatment. Leaving a message is acceptable.

_____ (initial) (date) _____

WALK INS: We do our best to accommodate those in acute pain. Please do not abuse this service.

LATE PATIENTS: If you come in after your appointment time you may have to wait for an opening.

AFTER HOURS: Dr. Hudson's after hours fee in $50.00 in addition to services rendered. Please leave a message at the office as Dr. Hudson checks the messages regularly. Please respect the doctor's private time and do not contact them at their home unless it is an absolute emergency.

FINANCIAL ARRANGEMENTS: Payment for care is due at the time of service-cash status. Exceptions must be agreed upon in writing prior to treatment. Cash, checks, Visa, and MasterCard are accepted.

INSURANCE: We are members of several insurance panels and may have arrangements with your carrier. Copays and deductibles are paid at the time of services after benefits are determined. Until insurance benefits are verified by our staff, you are considered a cash patient. If we are unable to obtain reliable information from your carrier, we cannot take assignment on your insurance; however, we will be happy to provide itemized bills. Acceptance of assignments is a courtesy representing a 60 day line of credit. You must understand and agree that health insurance policies are an agreement between the insurance carrier and yourself. PLEASE DIRECT ALL INSURANCE AND FINANCIAL INQUIRIES TO THE BILLING DEPARTMENT, NOT THE DOCTOR.

FORMS: Forms or paperwork requiring your chart pulled, records reviewed, and a signature are $20 per page. Forms or paperwork requiring review of chart, form completion, and/or narrative by the physician are $50 for every 10 minute increment, or part thereof, involving the physician's time.

FAMILY/GUESTS: Unless agreed upon first, it is preferable that adult patients be examined without spouse or guests in the room. It is distracting to the doctor to have more than one person answering questions during the examination. Children are allowed to accompany parents when necessary. We prefer you provide supervision for your child.

CHILDREN AS PATIENTS: Parents are expected to accompany children during examination. No child will be treated unless established as a patient.

NEW CONDITIONS: Please call ahead if you have a new problem when you have a regular follow up visit scheduled. Otherwise we will not have adequate time set aside for a complex visit.

YOUR RECORDS: We must have 24 hours notice to prepare your records for release. X-rays will be released to the patient with 24 hours notice and a signed release by the patient, indicating where they are going.

_____(initial) (date)_____

ASSIGNMENT OF BENEFITS

"I hereby assign payment to Hudson Chiropractic Office of all benefits due under the terms of my policy. Although your insurance policy is an agreement between yourself and your carrier, this office will process your insurance forms upon request. We will do our upmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason you must understand that you are responsible to make in full."

I understand that I am responsible for payment of this account, and hereby assume and guarantee payment of all related expenses incurred during treatment. If my current policy prohibits direct payment to the Dr., I hereby instruct and direct,_____
Insurance to make out the check to Hudson Chiropractic and mail to 3030 S. Tamiami Trail, Sarasota, FL 34239

I also hereby authorize the Hudson Chiropractic office to release any information pertinent to my case, to my insurance company, adjuster or attorney involved in my case.

PLEASE DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING IT

I have read and acknowledge the office policies of Hudson Chiropractic

SIGNATURE_____DATE_____

WITNESS_____