

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (First MI Last) _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____
Email: _____ Gender: M / F Marital Status: Single / Married / Other
Social Security #: _____ Date of Birth: _____
Student Status: Full Student / Part Student / Non-Student Employed: Y / N
Ethnicity: Hispanic or Latino / 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
*Referred By: (Name): _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____ Primary Care Physician: _____
Home: _____ Mobile: _____ Doctor's Phone: _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

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

PRIMARY INSURANCE

Insurance Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

SECONDARY INSURANCE

Insurance Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - (Relationship) _____

Other than Self:

Name: (First MI Last) _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

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

Patient No: _____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

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

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

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications and Supplements:

Allergies to Medications: NONE

Name	Reaction

Current Medications & Supplements: NONE

Name	Dosage	Frequency	Method

Past Health History: (Please list any past...)

Number of Falls in the last 24 months: _____ **Injuries?** Y or N

Surgeries: NONE

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: NONE

Date	Describe

Patient No: _____

Family Health History:

N/A

List relevant major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

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

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

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
- 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 of Hands, Ankles, or 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
- Ringing in the ears
- 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

Pregnancies:

Date	Outcome

Comments: _____

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 _____

Treating Doctor Signature _____ Date _____

Patient No: _____

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, please circle the number which most closely describes your condition **right now**.

<p>1. Pain Intensity</p> <p>0 1 2 3 4</p> <p>No pain Mild pain Moderate pain Severe pain Worst possible pain</p>	<p>6. Recreation</p> <p>0 1 2 3 4</p> <p>Can do all activities Can do most activities Can do some activities Can do a few activities Cannot do any activities</p>
<p>2. Sleeping</p> <p>0 1 2 3 4</p> <p>Perfect sleep Mildly disturbed sleep Moderately disturbed sleep Greatly disturbed sleep Totally disturbed sleep</p>	<p>7. Frequency of pain</p> <p>0 1 2 3 4</p> <p>No pain Occasional pain; 25% of the day Intermittent pain; 50% of the day Frequent pain; 75% of the day Constant pain; 100% of the day</p>
<p>3. Personal Care (washing, dressing, etc.)</p> <p>0 1 2 3 4</p> <p>No pain; no restrictions Mild pain; no restrictions Moderate pain; need to go slowly Moderate pain; need some assistance Severe pain; need 100% assistance</p>	<p>8. Lifting</p> <p>0 1 2 3 4</p> <p>No heavy weight Increased pain with heavy weight Increased pain with moderate weight Increased pain with light weight Increased pain with any weight</p>
<p>4. Travel (driving, etc.)</p> <p>0 1 2 3 4</p> <p>No pain on long trips Mild pain on long trips Moderate pain on long trips Moderate pain on short trips Severe pain on short trips</p>	<p>9. Walking</p> <p>0 1 2 3 4</p> <p>No pain; any distance Increased pain after 1 mile Increased pain after 1/2 mile Increased pain after 1/4 mile Increased pain with all walking</p>
<p>5. Work</p> <p>0 1 2 3 4</p> <p>Can do usual work plus unlimited extra work Can do usual work; no extra work Can do 50% of usual work Can do 25% of usual work Cannot work</p>	<p>10. Standing</p> <p>0 1 2 3 4</p> <p>No pain after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after 1/2 hour Increased pain with any standing</p>

Name _____ **PRINTED** _____ **Total Score** _____

Signature _____ Date _____

Doyle Chiropractic
684 Fairview Rd, Ste. A
Simpsonville, SC 29680

HIPPA

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant now. 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 consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGEMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully 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. By signing below, you hereby assign benefits to be paid 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: "Patients or authorized persons' 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."

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal 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, email and regular mail. Messages may be left on answering device/voicemail or with person answering your phone- home, work or mobile. Also in accordance with Health Insurance Portability and Accountability act of 1996 (HIPPA), updated September 23, 2013, this office is obliging 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.

ACKNOWLEDGMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment pan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMNT: 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 give to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Signature of Patient: _____

Date: _____

Printed Patient Name: _____

Date: _____

Signature of Parent or Guardian: _____

Date: _____

CONTINUE TO OTHER SIDE

Doyle Chiropractic
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Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms, etc.) often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____

Date: _____

Printed Patient Name: _____

Date: _____

Witness Signature: _____