

CASE HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Primary Method of Contacting You: H C E

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Sex: M F Marital Status: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

How did you hear about our office?

Referred by: \_\_\_\_\_ Other: \_\_\_\_\_  
Phone book Radio Newspaper

Name of Family

Doctor: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize Center of Chiropractic Neurology to inform my family doctor that I am receiving treatment here. \_\_\_\_\_ (init.)  
I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services, prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually). I also understand that if my account is sent to collections, 35% will be added to the balance owed.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, employer health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. I agree that a photocopy/facsimile of this agreement shall serve as the original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

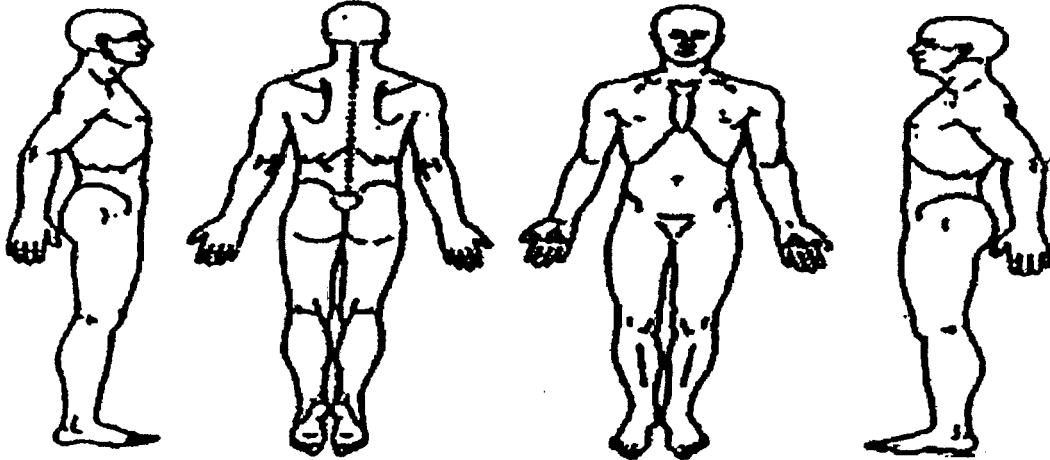
Center of Chiropractic Neurology 620 Jackson St. Sauk City, WI 53583 608-370-7328

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is today's problem caused by:  Auto Accident  Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- |                                   |  |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly                    |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion         |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion      |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion      |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> Other: _____              |

5. How are your symptoms changing with time?

- Getting Worse  Staying the Same  Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem now?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

8. How much has the problem interfered with your social activities?

- Not at all  A little bit  Moderately  Quite a bit  Extremely

Continue to page 2

**9. Who else have you seen for your problem?**

- Chiropractor       Neurologist       Primary Care Physician  
 ER physician       Orthopedist       Other: \_\_\_\_\_  
 Massage Therapist    Physical Therapist    No one

**10. How long have you had this problem?** \_\_\_\_\_

**11. How do you think your problem began?**

\_\_\_\_\_

**12. Do you consider this problem to be severe?**

- Yes       Yes, at times       No

**13. What aggravates your problem?**

\_\_\_\_\_

**14. What concerns you most about your problem; what does it prevent you from doing?**

\_\_\_\_\_

**15. What is your: Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Occupation** \_\_\_\_\_

**16. How would you rate your overall health?**

- Excellent       Very Good       Good       Fair       Poor

**17. What type of exercise do you do?**

- Strenuous       Moderate       Light       None

**18. Indicate if you have any immediate family members with any of the following:**

- Rheumatoid Arthritis       Diabetes       Lupus  
 Heart Problems       Cancer       ALS

*Continue to page 3*

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		<b>For Females Only</b>
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

22. List all surgical procedures you have had:

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23. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

24. What activities do you do outside of work?

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25. Have you ever been hospitalized?  No  Yes – if yes, why?

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26. Have you had significant past trauma?  No  Yes – if yes, explain

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27. Anything else pertinent to your visit today? \_\_\_\_\_

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Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Email address: \_\_\_\_\_@\_\_\_\_\_

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

DOB: \_\_\_/\_\_\_/\_\_\_ Gender (Circle one): Male / Female Preferred Language: \_\_\_\_\_

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? If you already have a list we can make a photocopy. (Please include regularly used over the counter medications) Yes \_\_\_\_\_ No \_\_\_\_\_ (if you have a list, we will accept it)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For office use only**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_

**CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

**Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

**Your right to limit uses or disclosures**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**Your right to revoke your authorization**

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## INFORMED CONSENT

Dear Patient,

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called "informed consent".

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, Inc.

**Stroke:** Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the brain stem. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA Vol. 37 No. 2, June 2, 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

**Disc Herniation:** Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes disc herniations in both the neck and the back. Yet occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem. These problems occur so rarely, that there are no available statistics to quantify their probability.

**Soft Tissue Injury:** Soft tissues primarily refer to muscles and ligaments. Muscles move the bones and ligaments limit the amount of joint movement. Rarely will chiropractic adjustments, traction, massage therapy, etc., tear some muscle or ligament fibers. If this does occur the result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

**Rib Fracture:** The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely will chiropractic adjustments "crack" or fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

**Physical Therapy Burns:** Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. If a burn occurs the result is a temporary increase in skin pain. In extreme cases, some blistering of the skin may occur. These problems occur so rarely that there are no available statistics to quantify their probability.

**Soreness:** It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

**Other Problems:** There may be other problems or complications that might arise from chiropractic treatment, other than those noted above. These other problems or complications occur so rarely that it is impossible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care, and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation. If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

\_\_\_\_\_  
Patient's Name Printed

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Parent/Guardian Signature for Minor

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Today's Date