Health History Form

Name: _____ Date: _____DOB_____ Age_____ Gender: Male/Female
SSN#: _____Address: _____ City, State, Zip: _____
Cell Phone: _____ Home Phone: _____ Email address: _____

Appointment reminders via text? YES / NO Occupation: _____ Employer's Name: _____

Who may we thank for referring you? _____ Single/Divorced/Widowed/Married (Spouse's Name: _____)

#of Children, Names, Ages & Gender_____

Main Health Concern History

Health Concerns: In order of Severity	Rate of Severity 1=Mild 10= Unbearable	How long have you had this?	Did this start with an injury?	Have you had this before?	Is this constant or comes/goes?
1.					
2.					
3.					
4.					

1. Please check all that apply when describing the pain? □ Sharp □ Soreness □ Throbbing □ Tingling □ Dull □ Stiffness □ Spasm □ Burning □ Ache □ Weakness □ Numbness □ Shooting
2. Does the pain travel anywhere else? □ YES or □ NO Describe: _____
3. How often is this present? □ Constant (81-100%) □ Frequent (51-80%) □ Occasional (26-50%) Intermittent (25% or less)
4. Since it started, has the pain gotten better, worse or stayed the same? _____
5. What makes your health concern worse?
   5.1. □ Nothing □ Walking □ Standing □ Sitting □ Exercise (moving) □ Lying Down □ Other
6. Have you seen anyone for this health concern? (Chiropractor, Medical Doctor, etc.) If so, who?
   _____
7. Please list all medications, including vitamins/supplements, you are taking and for what?
   _____
8. Please list any broken bones, surgeries, or hospitalizations you have had and when:
   _____
9. Please list any auto accidents or major slips/falls/traumas you have been involved in:_____
10. Spinal health is especially important during pregnancy; **any chance** that you are pregnant? **YES or NO**

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer___ Heart Attack ___Arthritis ___ Diabetes ___Cerebral Vascular ___ Other_____

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes **If yes whom**: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes:

_____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: ___

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely. **IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.**

_____ _____ _____

Printed Name Signature Date

Legal Guardian Signature _____ Date _____Relationship to Minor _____

Insurance Release of Authorization/Assignment of Benefits

I hereby authorize payment to be made directly to CTC Chiropractic 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 CTC Chiropractic for any and all services I receive at this office.

Insurance Verification Form

NAME OF PRIMARY INSURANCE CARRIER: _____**NAME OF SECONDARY INSURANCE CARRIER:** _____

Name of insured _____ Insured Date of Birth_____ Insured Social Security: _____

FEES: We have a zero balance policy. Payment for services is due at the time of services rendered. Payment options include; cash, check, debit/credit card, Amex, and HSA/HRA cards. Returned checks will be billed to the patient for the amount of the check as well as a returned check fee of $15.00. **We reserve the right to charge $35 late fee for all late payments.**

Patient's Signature _____ Date_____

INFORMED CONSENT

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE VERTEBRAL INJURY THAT COULD LEAD TO A STROKE. PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFIY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTHCARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE. WE DO NOT OFFER TO DIAGNOSE OR TREAT ANY DISEASE. **OUR FOCUS IN THIS OFFICE IS THE VERTEBRAL SUBLUXATION. HOWEVER, IF WE ENCOUNTER NON-CHIROPRACTIC OR UNUSUAL FINDINGS WE WILL ADVISE YOU. IF YOU DESIRE ADVICE, DIAGNOSES, OR TREATMENT FOR THOSE FINDINGS WE RECOMMEND THAT YOU SEEK ANOTHER HEALTHCARE PROVIDER. REGARDLESS OF WHAT THE DISEASE IS CALLED, WE DO NOT OFFER TO TREAT IT. NOR DO WE OFFER ADVICE REGARDING TREATMENT PRESCRIBED BY OTHERS. OUR ONLY PRACTICE OBJECTIVE IS TO LOCATE, ANALYZE AND CORRECT VERTEBRAL SUBLUXATION BY SPECIFIC NEUROLOGICAL BASED CHIROPRACTIC ADJUSTMENTS.** CHIROPRACTIC IS A VERY SPECIFIC SCIENCE, AUTHORIZED BY LAW TO ADDRESS SPINAL HEALTH CONCERNS AND NEEDS. CHIROPRACTIC IS A SEPARATE AND DISTINCT SCIENCE, ART AND PRACTICE. **IT IS NOT THE PRACTICE OF MEDICINE**. THE CHIROPRACTIC ADJUSTMENT PROCESS, AS DEFINED IN THE LAW OF THIS JURISIDICTION, INVOVLES THE APPLICATION OF A SPECIFIC DIRECTIONAL THRUST TO A REGION OR REGIONS OF THE SPINE WITH THE SPECIFIC INTENT OF RE-POSITIONING MISALIGNED SPINAL SEGMENTS. THIS IS A SAFE, EFFECTIVE PROCEDURE APPLIED OVER ONE MILLION TIMES EACH DAY BY DOCTORS OF CHIROPRACTIC IN THE UNITED STATES ALONE. **YOUR COMPLIANCE WITH CARE PLANS, HOME AND SELF-CARE, ETC. IS ESSENTIAL TO MAXIMUM HEALING AND OPTIMAL HEALTH. WE INVITE YOU TO SPEAK FRANKLY TO THE DOCTORS ON ANY MATTER RELATED TO YOU CARE AT THIS FACILITY.**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis. I have read and fully understand the above statements.

_____ _____ _____

Printed Name Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

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

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1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.