CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Today's Date / / Signature of Patient _____
Signature of Parent/Guardian _____

Patient Title: *(check one)* ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Dr. ◯ Prof. ◯ Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home Email _____ Work Email _____

Which email address would you like us to use to communicate with you? *(Check one)*
◯ Home ◯ Work

Contact Method *(Check one)*
◯ Primary Phone ◯ Secondary Phone ◯ Mobile Phone ◯ Home Email ◯ Work Email

Date of Birth / / Age _____ Gender *(Check one)* ◯ Male ◯ Female ◯ Unspecified

Marital Status *(Check one)* ◯ Single ◯ Married ◯ Other SSN _____

Employment Status *(Check one)*
◯ Employed ◯ FT Student ◯ PT Student ◯ Other ◯ Retired ◯ Self Employed

Race *(Check one)*

◯ White	◯ Black/African American	◯ Hispanic	◯ American Indian/Alaskan Native
◯ Asian	◯ Asian Indian	◯ Chinese	◯ Filipino
◯ Japanese	◯ Korean	◯ Vietnamese	◯ Native Hawaiian or other Pacific Island
◯ Samoan	◯ Guamanian or Chamorro	◯ Other_____	◯ I choose not to specify

Multi-Racial *(Check one)* ◯ Yes ◯ No ◯ Unknown

Ethnicity *(Check one)* ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ I choose not to specify

Preferred Language *(Check one)*

◯ English	◯ Spanish	◯ American Sign Language	◯ Chinese	◯ French	◯ German
◯ Tagalog	◯ Vietnamese	◯ Italian	◯ Korean	◯ Russian	◯ Polish
◯ Arabic	◯ Portuguese	◯ Japanese	◯ French Creole	◯ Greek	◯ Hindi
◯ Persian	◯ Urdu	◯ Gujarati	◯ Armenian	◯ I choose not to specify	

Verification Question *(Choose only one question by checking the question, then give the answer to that question)*

◯ What is the name of your favorite pet? ◯ In what city were you born? ◯ What high school did you attend?
◯ What is your favorite movie? ◯ What is your mother's maiden name? ◯ On what street did you grow up?
◯ What was the make of your first car? ◯ When is your anniversary? ◯ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ◯ Yes ◯ Former smoker ◯ Never been a smoker

If yes, how often do you smoke: ◯ Current every day smoker ◯ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

◯ 0 *No interest* ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 *Very Interested*

Current medications, including dosage if known
If there are no current medications, check here: ☐

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ☐

1) _____ 3) _____

2) _____ 4) _____

Occupation _____ **Employer** _____

Who referred you to us? _____ **How else did you hear about us?** _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ◯ **Improved** ◯ **Unchanged** ◯ **Getting Worse**

Is this condition interfering with your: ◯ **Work** ◯ **Sleep** ◯ **Daily Routine** **Other** _____

Other doctors or therapists who have treated THIS condition _____

_____

_____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name: _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ◯Yes ◯No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ◯Yes ◯No If yes, what kind? ◯Type I ◯Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ◯Yes ◯No ◯Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ◯Yes ◯No

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____ / _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ○ Heavy ○ Moderate ○ Light Hours per day _____

Physical Work ○ Heavy ○ Moderate ○ Light Hours per day _____

Exercise ○ Heavy ○ Moderate ○ Light Hours per week _____ Type _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine Cups/Day _____ *(Coffee, Tea, Cola)* No. of Years _____

Aspirin No./Day _____ No. of Years _____ Others _____

SYMPTOMS Mark the areas of your symptoms on the figure to the right.

Use the following symbols:

Aches ^^^^ **Numbness** oooo **Pins/Needles** ···· **Stabbing** ////

Mark an "X" on the following two lines:

How bad are your symptoms now?

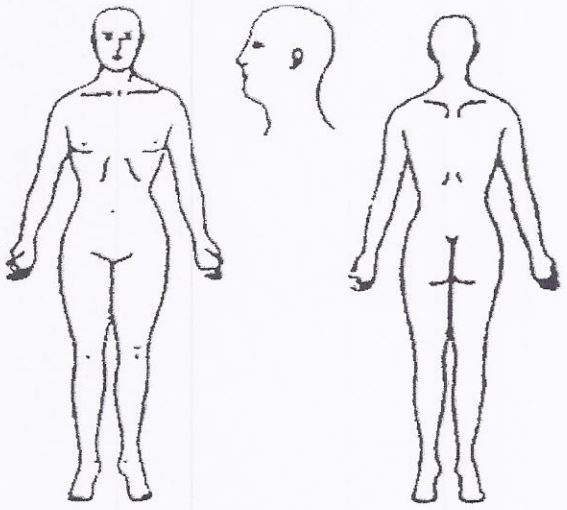
_____

None *Most Severe*

How bad have they been in the past?

_____

None *Most Severe*



Insurance Information

Name of Insured _____
How are they related to the patient? _____
Insurance Company _____
Policy# _____ Deductible Amount _____
Subscriber's Name _____ D.O.B. _____
Insurance ID# _____

Direct Payment to Doctor / Release of Records: I state that I have insurance with _____ and assign to this office all allowable insurance benefits payable to me for chiropractic services rendered to me (or my dependant). I further understand that regardless of coverage I am ultimately responsible for any charges incurred at this office. I hereby authorize Dr. Daniel W. Talley B.S.D.C. to release all health information in my file to any insurance company or adjuster necessary to process insurance claims for the benefits that are payable under the terms of my insurance policy.

Insured Signature _____ Date _____

American Chiropractic & Acupuncture
Patient Health Information (PHI) Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. We require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient Signature Date

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of an examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I understand that I will have the opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I understand I will have an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authorized signature if not Patient

American Chiropractic & Acupuncture
Financial Policy

Your insurance policy is an agreement between you and the insurance company. It is important that you understand your health and accident benefits listed in you policy. You or your guardian is personally responsible for any charges for services which are rendered to your account. There are many variations in the HMO's and PPO's of today. We request that you call your insurance company to get your Chiropractic Benefits within the first week of care. As a courtesy to you, our office will also call your insurance company to verify insurance coverage, BUT this is not a guarantee of what the insurance company will pay. We will try, to the best of our ability, ESTIMATE what your coinsurance/co-pay will be at each visit. It is our Office Policy to collect any deductibles, co-insurances or co-pays at EACH visit unless other arrangements are made.

ONCE NOTIFIED BY THE INSURANCE COMPANY THAT SERVICES RENDERED ARE NOT PAYABLE UNDER THE "MEDICAL NECESSITY" CLAUSE IN YOUR CONTRACT, YOU AGREE TO ACCEPT FULL RESPONSIBILITY FOR THOSE SERVICES. IF YOU ELECT TO CONTINUE CARE, YOU AGREE TO ACCEPT FULL RESPONSIBILITY FOR SERVICES RENDERED.

All insurance checks and payments will be assigned to our office. If you mistakenly receive an insurance check in your mail, please bring the check and all attached paperwork to our office so that we may properly credit your account.

Any overpayment made by your insurance company on your account will be refunded. Any balance not paid by the insurance company ultimately becomes your responsibility. If care is terminated by the patient or the doctor, payment for services is due in full immediately. A late fee of 1% per month will be assessed to the unpaid balance after 30 days.

Patients with no insurance:
Full payment of patient obligation is due at the time services are rendered. We accept cash, personal checks, Visa and MasterCard as forms of payment. As a courtesy, payment plans are available for you and your family. If your situation requires special consideration, please let us know.

Returned Checks: There will be a $25 charge for all returned check.

Missed Appointments:
We understand that there may be extenuating circumstances affecting your schedule, and we will do our best to accommodate your needs. We ask that out of respect for our office policies that a 24-hour notice be given to any appointment that needs to be cancelled or rescheduled. If this notice is not given, a $25 fee will be charged to you. This fee is patient responsibility and can not be billed to insurance.

In signing this form, I have read and understood this information.

SIGNED_____DATE_____