

# 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

**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	

**Patient No:** \_\_\_\_\_

**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: \_\_\_\_\_

Abundant Life Chiropractic  
Pinnacle C.O.P. Manual-1.0  
Revised 10.21.2014

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

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 at this time. 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.

**ACKNOWLEDGMENT 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 arrangement between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to BE paid directly 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: "PATIENT'S OR AUTHORIZED PERSON'S 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."

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

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

**ACKNOWLEDGEMENT:** By signing below you have acknowledge 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 given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

**CLINICAL SUMMARY:** I choose to decline the receipt of my clinical summary after every visit. *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Signature of Patient: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

**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: \_\_\_\_\_

Witness Signature: \_\_\_\_\_