INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Married / Other / Single

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** _____

***Referred By:** _____

Ethnicity: Hispanic or Latino / Other **Preferred Language:** _____

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White **Smoking Status**: Every Day / Some Days / Former / Never

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EMERGENCY CONTACT INFORMATION

Full Name: _____ **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

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

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:** _____

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

Other than Self
Full Name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

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: _____

Began When? ____/____/_____ **Describe how this began:** _____

_____

_____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

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 previous Surgery or Interventions in this area?** *(Describe)* _____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

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

Medications:

Allergies to Medications: ***NONE*** *(List)* _____

_____

Current Medications: ***NONE***

(Already have a list? We can make a copy.) _____

_____

_____

_____

_____

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

Surgeries – Date, Type, and Reason: ***NONE***

_____

_____

_____

_____

Major Injuries/Traumas: ***NONE*** _____

_____

_____

_____

Major Hospitalizations: ***NONE*** _____

_____

_____

Patient No: _____

Family Health History: *(Please mark N/A if not relevant.)*

List *relevant* major health problems of immediate relatives:

_____

_____

_____

Deaths in immediate family: *(Cause and at what Age?)*

_____

_____

_____

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

_____

_____

_____

_____

Habits:

Cigarettes – *(# day)* _____

Alcohol – *(amount/day)* _____

Coffee/Tea – *(cups/day)* _____

Rec. Drugs *(List)* _____

REVIEW OF SYSTEMS

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
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ 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 with Outcome & Date:

_____
_____
_____

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: _____

BACK & NECK CARE CENTER OF BEDFORD

2803 Central Dr. Bedford, TX 76021
Dr. Richard Chatfield

Health Insurance Portability & Accountability Act (HIPPA) Consent Form

THIS NOTICE DESCRIBES HOW RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

In the course of your care as a patient at our office, we may use or disclose personal and health related Information about you in the following ways: 1) Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment. 2) Your health records as well as your billing records may be disclosed to another party, such as insurance carriers (HMO, PPO, etc.), or your employer (if they are responsible for payment). 3) Your name, address, phone number, email and your health records may be used to contact you regarding appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about your treatment alternatives or other health related information. A message may be left on your voicemail or answering machine. 4) Your name may be listed on our referral board of referring patients. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail or e-mail information to you regarding your health care or about the status of your account. By signing below, I acknowledge that I have read the above information and give full disclosure of my information.

Patient's/Guardian Signature_____Date_____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's/ Guardian Signature_____Date_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic treatment or any clinic services that he deems necessary in my case; and I further authorize him to disclose all or any part of my (patient's) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge including, but not limited to; hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or patient's employer.

Patient's/Guardian Signature_____Date_____

BACK & NECK CARE
CENTER OF BEDFORD
chiropractic & rehabilitative care

Richard
Chatfield, D.C.

Certified:
- National Board of Chiropractic Examiners
- American Board of Disability Analysts
- American Academy of Pain Management
- Academy of Disability Evaluating Physicians

Member:
- American Chiropractic Association
- Texas Chiropractic Association

Effective relief for:
- Back & Neck Pain
- Headaches
- Leg, Arm, and Shoulder Pain
- Whiplash
- Carpal Tunnel Syndrome
- Work Injuries
- Auto Injuries
- Sport Injuries

Chiropractic & Rehabilitative Services:
- Gentle Adjustments
- In-Office X-ray & Therapy
- Post-Injury Rehabilitation
- Physical Capacities Evaluations
- Pre-Employment Strength Testing

For Your Convenience:
- Insurance accepted & filed for you
- Member of Multiple HMO/PPO's
- Workers Compensation Assistance Available
- Visa, MasterCard, Novus and American Express accepted
- Flexible Payment Options
- Walk-ins Welcome

Authorization To Treat a Minor Child

I, _____, do hereby authorize The Back & Neck Care Center of Bedford to administer chiropractic care as deemed necessary to my child, _____.

_____
Parent or legal guardian Signature

_____
Date

_____
Witness

2803 Central Drive • Bedford, Texas 76021 • (817) 283-6100 • Metro: 267-4000 • Fax: (817) 283-9536