

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: _____

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 judgment 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. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours. Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Richard Chatfield DC, Chiropractor to save these electronically for me and not print them out after each visit. I understand that, upon request that these reports are available to be printed or emailed to me for review.

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 my 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 _____