

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ___/___/___

PATIENT INFORMATION

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

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

Date of Birth: _____ Gender: Male Female Social Security #: _____

Home: _____ Mobile: _____ Work: _____

Email: _____

Preferred Method of Contact: Text Email Phone - Home, Mobile, or Work Other: _____

*Referred By: (Name) _____

Family Friend Co-Worker Doctor Other: _____

Race & Ethnicity: (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Decline

Preferred Language:

- English
- Spanish
- Other: _____
- Decline

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____

Primary Care Physician: _____

Home: _____ Mobile: _____

Doctor's Phone: _____

Relationship:

Child Parent Spouse Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

No Auto Work Other: _____

Where would you like statements sent?

Self Other (Details below)

Will we be working with insurance? No Yes (Details)

Name: _____

Primary: _____ ID#: _____

Address: _____

Secondary: _____ ID#: _____

Phone: _____ Email: _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: _____

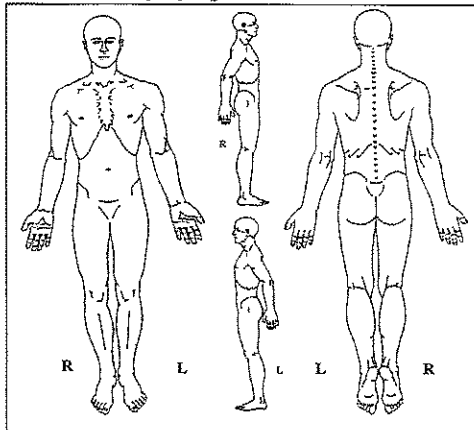
Secondary Complaints: _____

When did it start? ____/____/____ What happened? _____

Which daily activities are being affected by this condition? _____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: _____

Does it radiate?

- No Yes (Please indicate on drawing)

Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: _____
- Other: _____

Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: _____

Previous Treatment:

- None
- Chiropractor _____
- Medical Doctor _____
- Physical Therapy _____
- ER/Urgent Care _____
- Orthopedic _____
- Other: _____

Previous Diagnostic Testing:

- None
- X-rays _____
- MRI _____
- CT _____
- Other: _____

*Women: Are you pregnant?

- No Last Menstrual Period: ____/____/____
- Yes Due date: ____/____/____

Present Illness Comments:

Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

Frequency:

- Off & On
- Constant

Prescription Medications & Supplements: None

- Yes (List - Name, dosage, frequency) _____
- _____
- _____
- _____

Allergies to Medications: No known drug allergies

- Yes (List - Name and reaction) _____
- _____
- _____
- _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

Print Name: (First MI Last) _____

Account No: _____

ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) _____

Today's Date: _____

AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- Was anyone else in the vehicle with you? No Yes - (Number of people) _____
- You were? Front seat – Driver / Passenger Rear Seat– Behind Driver / Middle / Behind Passenger / 2nd Row / 3rd Row
- Name of Driver, if not self: _____ Name of Driver of other vehicle: _____
- Did airbags deploy? No Yes Did Police arrive? No Yes Using Seatbelt? No Yes
- Did you strike the windshield or object in car? No Yes - (Describe) _____
- Were you knocked unconscious? No Yes (How long?) _____
- Where was your vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Where was the other vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: _____
- Your Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____
 - Address: _____ City: _____ State: _____ Zip: _____
- Other's Auto Ins: _____ Policy #: _____ Claim #: _____ Phone #: _____
 - Address: _____ City: _____ State: _____ Zip: _____

WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: _____ Occupation: _____ Claim #: _____
Address: _____ City: _____ State: _____ Zip: _____
Contact Person: _____ Phone: _____ Email: _____

GENERAL ACCIDENT/INJURY INFORMATION – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Date of Accident: ____/____/____ Time: ____:____ AM / PM

Please describe the accident in as much detail as possible? _____

Before the accident/injury:

- Have you ever had any complaints in the involved area before? No Yes
 - If yes - Were they present at the time of the accident/injury? No Yes
 - If yes - Summarize these complaints prior to the accident: _____
- Were you capable of performing all of your work activities without restriction? No Yes

At the time of the accident/injury:

- Did you feel pain immediately after the accident? No Yes Later that day Next day When? _____
- Were you taken anywhere after the accident? No Yes Later that day Next day When? _____
 - If yes, How? _____ Where? _____
 - If yes, Did you receive treatment? No Yes - (Describe) _____

Since the accident/injury:

- Are your symptoms: Improving? Getting Worse? The Same?
- Are your work activities restricted as a result of this accident/injury? No Yes - (How?) _____
- Have you missed any work since this accident? No Yes - (Dates?) _____
- Have you retained an Attorney? No Yes - Name: _____ Phone: _____
 - Address: _____ City: _____ State: _____ Zip: _____

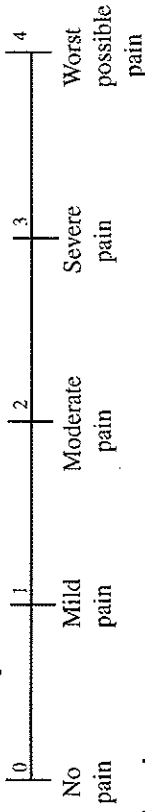
Patient No: _____

Functional Rating Index

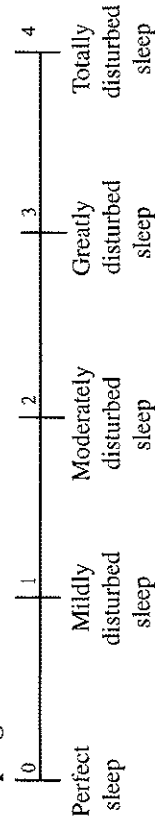
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

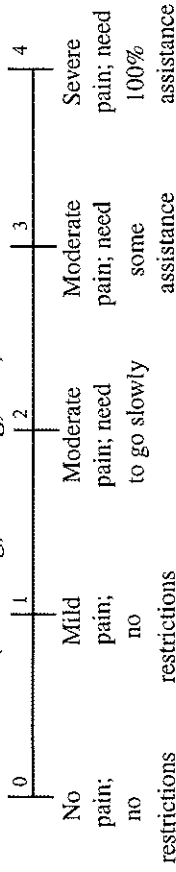
1. Pain Intensity



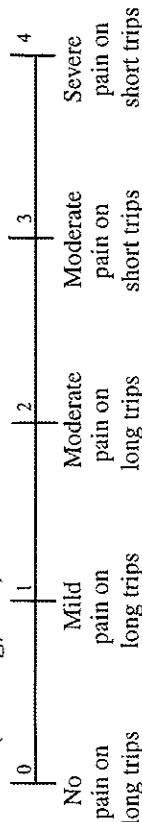
2. Sleeping



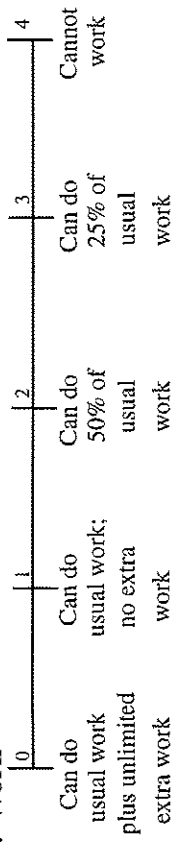
3. Personal Care (washing, dressing, etc.)



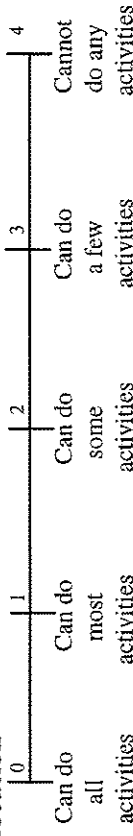
4. Travel (driving, etc.)



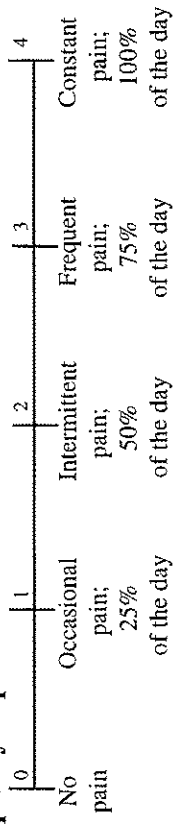
5. Work



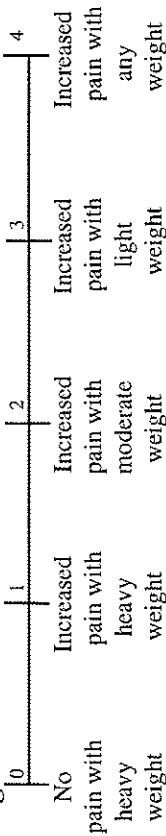
6. Recreation



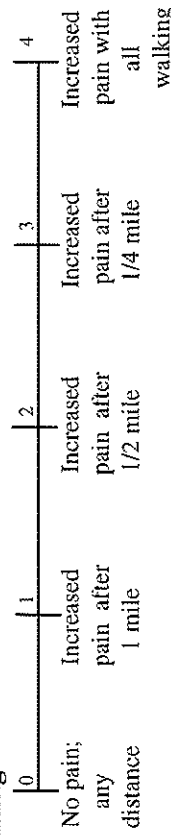
7. Frequency of pain



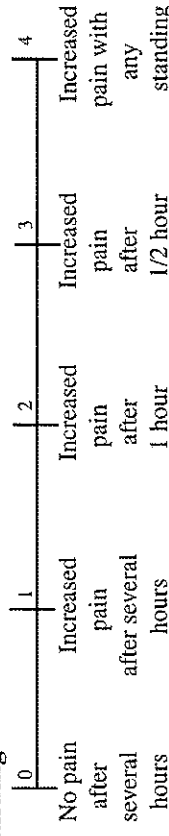
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Total Score _____

Date _____

Cates Chiropractic Clinic, LLC

4425 W Zoo Blvd, Suite 4 Wichita, KS 67212

(316)-945-5998 ccconzoo@yahoo.com

Notices of Privacy Practices-HIPPA

I understand that, under the Health Insurance Portability & Accountability Act 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to : Conduct, plain, and direct my treatment and follow-up amount the multiple healthcare providers who may be involved in the treatment directly and indirectly; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessment and physician certifications. I have been informed by you and your Notice of Privacy Practices containing a more complete description of the use and disclosures of my health information. I have been given the right to change its Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you take action relying on the account.

Informed Consent

Even though Chiropractic is considered to be a safe form of healing there is a remote chance for adverse effects to occur either temporarily or permanently. If you have any concerns about this statement of the possibilities of adverse effects please ask Dr. Rebekah Cates. I have read and understand this clause and hereby authorize Dr. Rebekah Cates, and whomever she may designate as her assistants to administer treatment, physical examination, X-ray studies, Chiropractic care, therapy, or clinic services that she deems necessary in my care. The authorization applies to all services rendered by Cates Chiropractic Clinic, LLC until it is revoked, in writing by me or my legal representatives.

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that she deems necessary in my case and I further authorize her to disclose all or any part of my patient's record to any person or corporation which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part compensation carriers, welfare funds of the patients employer.

CCR Disclaimer

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of documentation and regulatory requirements and is available for my review. At this time, I am asking Cates Chiropractic Clinic to save these electronically for me and not print the out after each visit. I understand that, upon request that these reports are available to be printed or email to me for review.

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount 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, any fees for professional services rendered to me will be immediately due and payable. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown.

Medicare

I request the payment of authorized Medicare benefits be made on my behalf to: "Cates Chiropractic Clinic or Rebekah Cates, D.C" for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits or the benefits payable to related services.

Credit Card on File Policy

We require a valid credit card, debit card or HSA card be kept on file for all patients. The card information is stored electronically in an encrypted form. Your signature below authorizes us to charge your card with you consent or when you balance becomes 90 days past due. By signing below, I acknowledge that I have or may in the future give Cates Chiropractic Clinic, LLC a credit card, debit card or HSA card to be saved on my family's account. I authorize Cates Chiropractic Clinic, LLC to charge my card with my consent or when my account balance becomes 90 days past due.

Print Patient Name: _____
Authorized Signature: _____
Relationship to Patient: _____
Date: _____