

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: _____

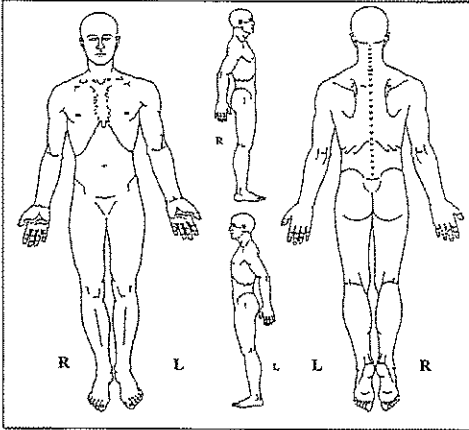
Secondary Complaints: _____

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

Which daily activities are being affected by this condition? _____

MAJOR COMPLAINT

Location of Symptoms and Radiation



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

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

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:

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: _____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

Illnesses:

- Asthma
- Autoimmune Disorder (Type) _____
- Blood Clots
- Cancer (Type) _____
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: _____

Hospitalizations: (Non-surgical with Date)

Surgeries: (If yes, provide type & surgery date)

- Cancer
- Orthopedic
 - Shoulder – R / L _____
 - Elbow/Forearm – R / L _____
 - Wrist/Hand – R / L _____
 - Hip – R / L _____
 - Knee – R / L _____
 - Ankle/Foot – R / L _____
- Spinal Surgery
 - Neck: _____
 - Back: _____
- Other: _____

Medical History Comments:

Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: _____

FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown Unremarkable

Family History Comments:

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: Single Married Divorced Other

Children: None 1 2 3 4

Other: _____

Student Status: Full Student Part Student Non-Student

Highest level of Education: High School College Grad.

Post Grad. Other: _____

Employed: No Yes (Occupation) _____

Dominant Hand: Right Left Ambidextrous

Social History Comments: _____

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) _____

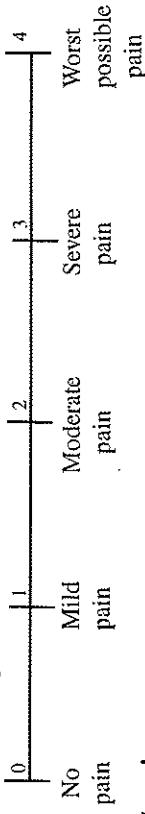
Account No: _____

Functional Rating Index

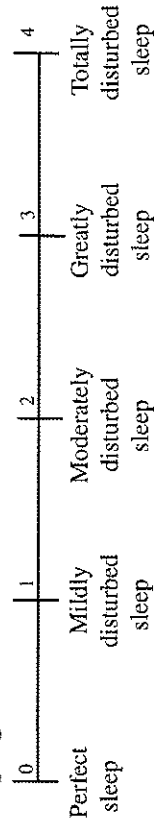
For use with Neck and/or Back Problems only.

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.**

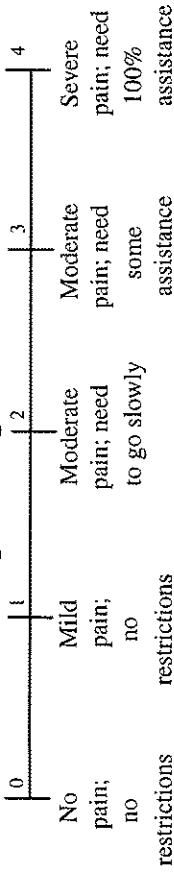
1. Pain Intensity



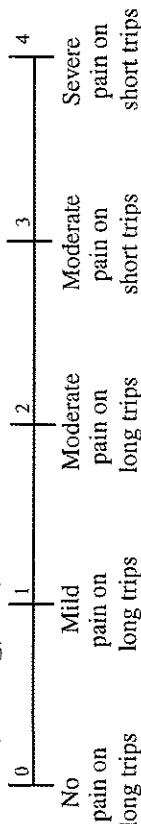
2. Sleeping



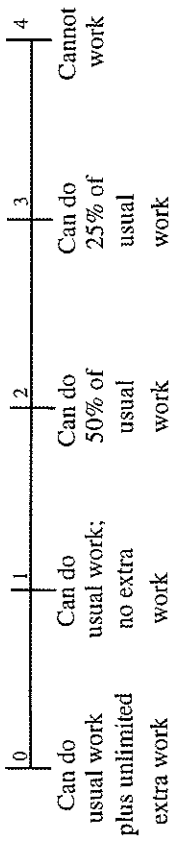
3. Personal Care (washing, dressing, etc.)



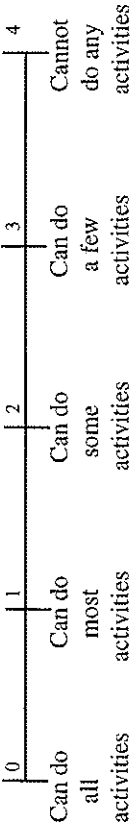
4. Travel (driving, etc.)



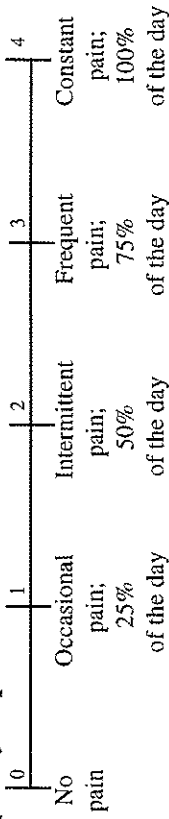
5. Work



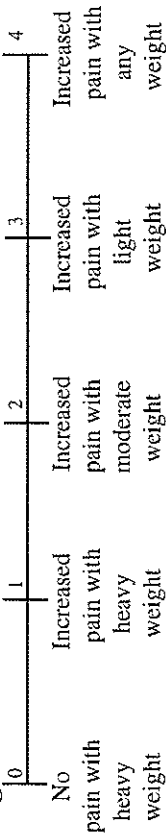
6. Recreation



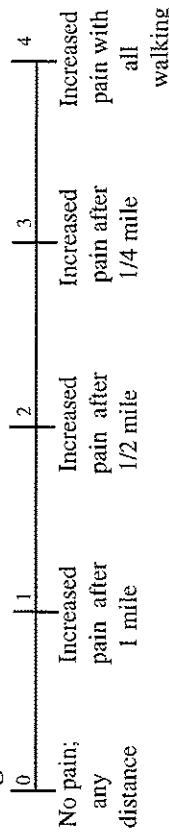
7. Frequency of pain



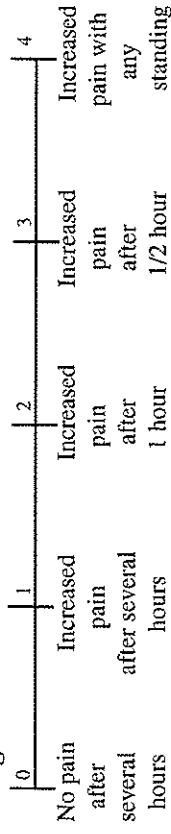
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature _____

Date _____

Total Score _____

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: _____

CONSENT FOR TREATMENT OF MINOR

Date: _____

I hereby authorize: _____

Doctor's Name

and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

Minor Patient's Name

Printed Name of Parent or Guardian

Signature of Parent or Guardian

Date

Witness

Date

Parent Remarks: _____
