

# Chiropractic Case History/Patient Information

**Date:** \_\_\_\_\_ **Patient #** \_\_\_\_\_ **Doctor:** \_\_\_\_\_  
**Name:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**E-mail address:** \_\_\_\_\_ **Fax #** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**Age:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Marital:** M S W D  
**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
**Employer's Address:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_  
**Spouse:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
**How many children?** \_\_\_\_\_ **Names and Ages of Children:** \_\_\_\_\_

**Name of Nearest Relative:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**How were you referred to our office?** \_\_\_\_\_

**Family Medical Doctor:** \_\_\_\_\_

**\*When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?** \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical    ☐ Medical Savings Account & Flex Plans    ☐ Medicare    ☐ Auto Accident    ☐ Other  
☐ Worker's Compensation    ☐ Cash

**Name of Primary Insurance Company:** \_\_\_\_\_

**Name of Secondary Insurance Company (if any):** \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Guardian's Signature Authorizing Care:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

**HISTORY OF PRESENT AND PAST ILLNESS:**

Chief Complaint: Purpose of this appointment: \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Is this due to: Auto\_\_\_ Work\_\_\_ Other\_\_\_\_\_

Have you ever had the same or a similar condition? Yes No If yes, when and describe: \_\_\_\_\_

Days lost from work: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

Do you have a history of stroke or hypertension? \_\_\_\_\_

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Do you have any allergies to any medications? Yes No

If yes, describe: \_\_\_\_\_

Do you have any allergies of any kind? Yes No

If yes, describe: \_\_\_\_\_

Do you have any Congenital Condition? \_\_\_Yes \_\_\_ No If YES, Describe \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.**N = Now****P = Previously**

Headaches \_\_\_\_\_ Frequency \_\_\_\_\_  
 Neck Pain \_\_\_\_\_  
 Stiff Neck \_\_\_\_\_  
 Sleeping Problems \_\_\_\_\_  
 Back Pain \_\_\_\_\_  
 Nervousness \_\_\_\_\_  
 Tension \_\_\_\_\_  
 Irritability \_\_\_\_\_  
 Chest Pains/Tightness \_\_\_\_\_  
 Dizziness \_\_\_\_\_  
 Shoulder/Neck/Arm Pain \_\_\_\_\_  
 Numbness in Fingers \_\_\_\_\_  
 Numbness in Toes \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_  
 Difficulty Urinating \_\_\_\_\_  
 Weakness in Extremities \_\_\_\_\_

Loss of Balance \_\_\_\_\_  
 Fainting \_\_\_\_\_  
 Loss of Smell \_\_\_\_\_  
 Loss of Taste \_\_\_\_\_  
 Unusual Bowel Patterns \_\_\_\_\_  
 Feet Cold \_\_\_\_\_  
 Hands Cold \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Muscle Spasms \_\_\_\_\_  
 Frequent Colds \_\_\_\_\_  
 Fever \_\_\_\_\_  
 Sinus Problems \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Indigestion Problems \_\_\_\_\_  
 Joint Pain/Swelling \_\_\_\_\_  
 Menstrual Difficulties \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

**N = Now****P = Previously**

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

**SOCIAL HISTORY**

Please indicate beside each activity whether you engage in it:

**O = OFTEN   S = SOMETIMES   N = NEVER**

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify) _____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

**FAMILY HISTORY**

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient \_\_\_\_\_

Signature of Patient/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

**Office Use Only**

- ☐ 1
- ☐ 4-5
- ☐ >5

Patient #: \_\_\_\_\_

## Pain Drawing

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Examiner: \_\_\_\_\_

### TELL US WHERE YOU HURT.

***Please read carefully:***

*Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

Ache >>>>>

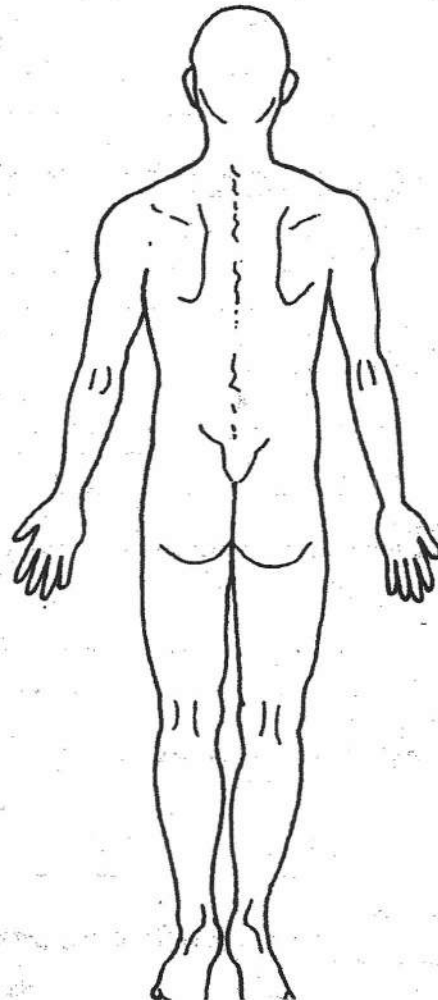
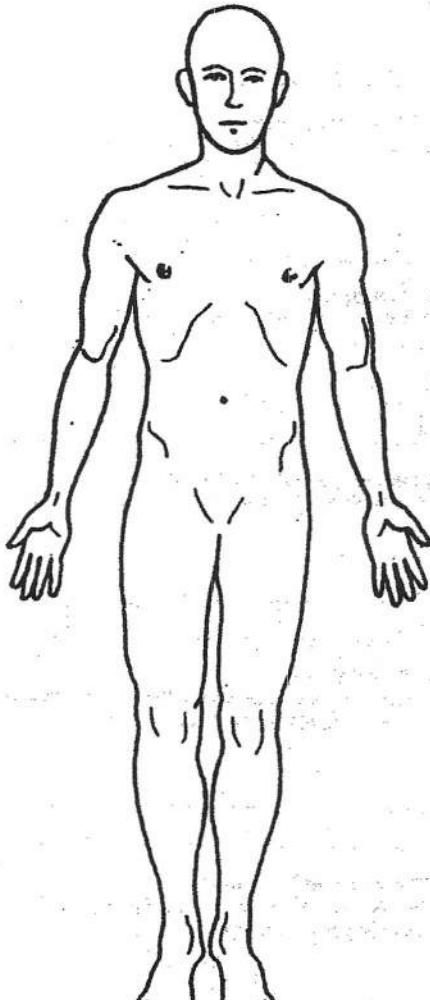
Burning x x x x

Numbness =====

Stabbing /////

Pins & Needles o o o o

Throbbing ~~~~~





## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

*For further information regarding this notice, please contact our Doctor at 209-581-1776*

PATIENT NAME:

## ARBITRATION AGREEMENT

**Article 1 - Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2- All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3- Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation. Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4- General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5- Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6- Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. \_\_\_\_\_ Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE X	(Date)
(Or Patient Representative)	(Indicate relationship if signing for patient)
OFFICE SIGNATURE X	(Date)

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE



## CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or off ice listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE X

(Or Patient Representative)

(Date)

(Indicate relationship if signing for patient)

**ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE**



**TO: Medicare Patients**

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

1. WE WILL FILE ALL MEDICARE CLAIMS.
2. WE WILL FILE ALL MEDICARE SECONDARY/SUPPLEMENTAL INSURANCE.
3. WE ARE PARTICIPATING PROVIDERS WITH MEDICARE WHICH MEANS THAT MEDICARE PAYS US DIRECTLY, HOWEVER, MEDICARE PATIENTS MUST MEET AN ANNUAL \$131 DEDUCTIBLE, WHICH WE ARE REQUIRED TO COLLECT AT THE BEGINNING OF SERVICES FOR EACH CALENDAR YEAR. SUPPLEMENTAL COVERAGE MAY PAY THE DEDUCTIBLE BUT IF NO SUCH COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE.
4. MEDICARE PAYS FOR 80% OF ALLOWED CHARGES. SUPPLEMENTAL COVERAGE MAY PAY THE 20%, BUT IF NO COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE.
5. MEDICARE DOES NOT PAY FOR MAINTENANCE CARE. THIS WILL BE YOUR RESPONSIBILITY.
6. MEDICARE DOES NOT PAY FOR ALL OF YOUR HEALTH CARE COSTS. THE FACT THAT MEDICARE DOES NOT PAY FOR A PARTICULAR ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT.

**MEDICARE PAYS FOR:**

Manual manipulation of the spine  
-IF SUPPORTED BY X-RAY AND/OR EXAMINATION  
-After the deductible is met  
-Depending upon the condition

**MEDICARE DOES NOT PAY FOR:**

-Examinations  
-Laser therapy  
-X-rays  
-Nutritional supplements  
-Orthopedic supplies  
-Maintenance care  
-Rehab

If you have questions regarding these guidelines, please ask, we are here to help you!

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.

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Signature of patient or person acting on patient's behalf

Date