CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Today's Date / / Signature of Patient _____

Signature of Parent/Guardian _____

Patient Title: (check one) ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Dr. ◯ Prof. ◯ Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home Email _____ Work Email _____

Which email address would you like us to use to communicate with you? (Check one)

◯ Home ◯ Work

Contact Method (Check one)

◯ Primary Phone ◯ Secondary Phone ◯ Mobile Phone ◯ Home Email ◯ Work Email

Date of Birth / / Age _____ Gender (Check one) ◯ Male ◯ Female ◯ Unspecified

Marital Status (Check one) ◯ Single ◯ Married ◯ Other SSN _____

Employment Status (Check one)

◯ Employed ◯ FT Student ◯ PT Student ◯ Other ◯ Retired ◯ Self Employed

Race (Check one)

◯ White ◯ Black/African American ◯ Hispanic ◯ American Indian/Alaskan Native
◯ Asian ◯ Asian Indian ◯ Chinese ◯ Filipino
◯ Japanese ◯ Korean ◯ Vietnamese ◯ Native Hawaiian or other Pacific Island
◯ Samoan ◯ Guamanian or Chamorro ◯ Other _____ ◯ I choose not to specify

Multi-Racial (Check one) ◯ Yes ◯ No ◯ Unknown

Ethnicity (Check one) ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ I choose not to specify

Preferred Language (Check one)

◯ English ◯ Spanish ◯ American Sign Language ◯ Chinese ◯ French ◯ German
◯ Tagalog ◯ Vietnamese ◯ Italian ◯ Korean ◯ Russian ◯ Polish
◯ Arabic ◯ Portuguese ◯ Japanese ◯ French Creole ◯ Greek ◯ Hindi
◯ Persian ◯ Urdu ◯ Gujarati ◯ Armenian ◯ I choose not to specify

Verification Question (Choose only one question by checking the question, then give the answer to that question)

◯ What is the name of your favorite pet? ◯ In what city were you born? ◯ What high school did you attend?
◯ What is your favorite movie? ◯ What is your mother's maiden name? ◯ On what street did you grow up?
◯ What was the make of your first car? ◯ When is your anniversary? ◯ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ◯ Yes ◯ Former smoker ◯ Never been a smoker

If yes, how often do you smoke: ◯ Current every day smoker ◯ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

No interest Very Interested

Current medications, including dosage if known.
If there are no current medications, check here: ☐

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ☐

1) _____ 3) _____

2) _____ 4) _____

Occupation _____ Employer _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major complaint? _____

_____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition: ◯ Improved ◯ Unchanged ◯ Getting Worse

Is this condition interfering with your: ◯ Work ◯ Sleep ◯ Daily Routine Other _____

Other doctors or therapists who have treated THIS ____ condition _____

_____

_____

What do you think caused this condition? _____

List surgical operations and years: _____

_____

_____

Do you have a family physician? Name : _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ◯ Yes ◯ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ◯ Yes ◯ No If yes, what kind? ◯ Type I ◯ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ◯ Yes ◯ No ◯ Not Sure

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back_____ spine in the past 28 days? ◯ Yes ◯ No

To be performed by clinic staff:

Height: _____inches Weight: _____ pounds BP: _____ / _____

REVIEW OF SYSTEMS Check only the ones you now have____ or have had__ in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____
Age at First Period _____
Duration of Cycle _____
Duration of Flow _____
No. of Pregnancies _____
No. of Births _____
No. of Miscarriages _____
No. of Abortions _____
Menstrual Flow ☐Heavy ☐Mod ☐Light
Last Period _____
Last Pap Smear _____
Last Vaginal Exam _____
Last Mammogram _____
Last Prostate Exam _____

Patient Name _____ Number _____ Date _____

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION	
DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE

A +	☐	A -	☐
B +	☐	B -	☐
AB +	☐	AB -	☐
O +	☐	O -	☐

Other _____

BLOOD TRANSFUSIONS

Date _____

Date _____

Date _____

Date _____

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

Hay Fever	☐	Parasites	☐
Mumps	☐	Epilepsy	☐
Rheumatic Fever	☐	Paralysis	☐
Allergies	☐	Polio	☐
Angina	☐	Mental Illness	☐
Cancer	☐	Alcoholism	☐
Tumor	☐	Depression	☐
Blood Disease	☐	Nervous Breakdown	☐
Leukemia	☐	Migraine	☐
Heart Trouble	☐	Gout	☐
Varicose Veins	☐	Hemorrhoids	☐
Phlebitis	☐	Prostate Problems	☐
Hypertension	☐	Sexual Problems	☐
Stroke	☐	Gonorrhea	☐
Ulcers	☐	Syphilis	☐
Jaundice	☐	Diabetes	☐
Skin Trouble	☐	Bladder Trouble	☐
Gallstones	☐	Kidney Stones	☐
Liver Trouble	☐	Kidney Infections	☐
Hepatitis	☐	Dysentery	☐

Date of Last Chest X-Ray _____ ◯Normal ◯Abnormal

Last TB Skin Test _____ ◯Normal ◯Abnormal

Allergies: _____

_____

_____

_____

_____

Patient Name _____ Number _____ Date _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ○Heavy ○Moderate ○Light Hours per day _____

Physical Work ○Heavy ○Moderate ○Light Hours per day _____

Exercise ○Heavy ○Moderate ○Light Hours per week _____ Type _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine Cups/Day _____ No. of Years _____
(Coffee, Tea, Cola)

Aspirin No./Day _____ No. of Years _____ Others _____

SYMPTOMS Mark the areas of your symptoms on the figure to the right.

Use the following symbols:

Aches ⊠⊠⊠ Numbness oooo Pins/Needles ···· Stabbing ////

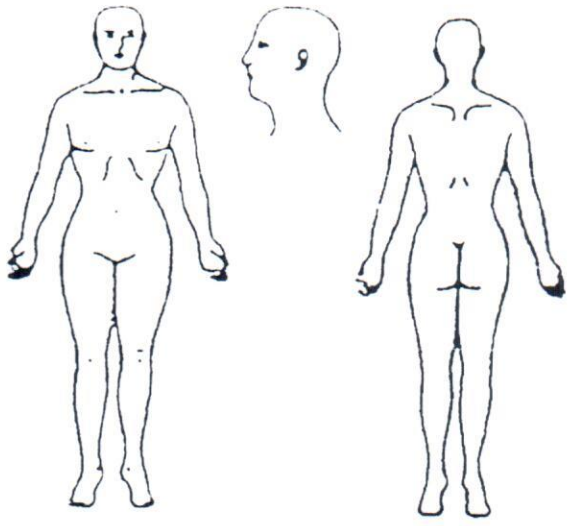
Mark an "X" on the following two lines:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe



Insurance Coverage Information

Medical Insurance:

Insurance Carrier: _____ Phone: _____

Policy Holder name: _____ Policy Number: _____

Group Number: _____

Workers Compensation Injury:

Employer: _____ Work Number: _____

Address: _____ Supervisor: _____

Was injury/accident reported to supervisor? Y / N Date: _____ Time: _____

Workers Comp Carrier: _____ Policy #: _____

Carriers Phone: _____ Adjuster: _____

Claim Number: _____

Auto / Personal Injury:

Do you have "Med Pay" on your Auto Policy: Yes / No Amount: $ _____

Insurance Carrier Name: _____ Phone: _____

Adjuster: _____ Claim Number: _____

Third Party Payer (other involved vehicle insurance)

Third Party (Person at Fault's) Name: _____ Ph: _____

THEIR Insurance Carrier: _____ Ph: _____

Address: _____

Adjuster: _____ Claim Number: _____

Patient Name: _____ **Date:** _____

WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completed and return to office.

Employee's name & address: _____

_____

_____

Phone number: _____

Occupation: _____

Age: _____ Sex: ☐ M ☐ F

Employer's name & address: _____

_____

_____

Phone number: _____

Type of business (retail, manufacturing, construction, etc.) _____

_____

Workers Compensation Insurance Carrier: _____

On what date did your injury occur? _____ What time? _____ AM PM

What address were you at when you were injured? _____

_____

Did you notify your employer of this injury? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No

If Yes, please give name & address: _____

_____

_____

Are you currently in litigation for this injury? ☐ Yes ☐ No ☐ Maybe

Please explain how the injury or illness occurred: _____

_____

_____

What injuries did you suffer? _____

_____

_____

When was the last day you worked? _____

When did you return to work? _____

When was your first examination? _____

Who examined you? _____

_____

_____

Check one, if known: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

What was doctor's diagnosis? _____

(Please complete opposite side.)

Have you received any treatments prior to visiting this office? ☐ Yes ☐ No

What treatments did you receive? _____

_____

Have you ever injured this area before? ☐ Yes ☐ No

If Yes, when did the injury occur? _____

Did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries prior to this injury, please list doctor or doctors consulted: _____

_____

_____

Do you have other injuries or illnesses that affect your employment? ☐ Yes ☐ No

If Yes. please explain: _____

_____

In your work, do you favor one part of your body more than others? ☐ Yes ☐ No

If Yes. please explain: _____

_____

Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Have you ever had a Worker's Compensation claim before? ☐ Yes ☐ No

Before the injury were you capable of working on an equal basis with others your age?

☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ improving? ☐ getting worse? ☐ the same?

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed By patient

_____

Witness

WORKER'S COMPENSATION AUTHORIZATION

Patient Name _____

Date of Accident _____

Disability: Date Last Worked _____ Date Returned to Work _____

Employer Name _____

Address _____

_____

Phone _____

Person to Contact _____

Worker's Compensation Carrier

Name _____

Address _____

_____

Phone _____

Person to Contact _____

Do you wish billing to be forwarded to employer or insurance carrier?

☐ Employer

☐ Insurance Carrier

The above patient has advised me of his work-related injury and that he/she is being treated by:

Provider Name _____

Address _____

_____

Phone _____

Person to Contact _____

_____ _____

Signature Authorized Representative Date

_____

Please Print Name

BAY CITY CHIROPRACTIC
Standard Fees and Financial Policies

Initial Examination:	$79 - $230
X-rays:	$50 - $175
Office Spinal Adjustment:	$40 - $60
Medicare Allowable Manipulation:	$27.90 - $34.02
Therapies:	
Electric Muscle Stimulation:	$35
Ultrasound:	$40
Hot/Cold Packs:	$30
Therapeutic Exercise:	$60
Neuromuscular Therapies:	$60 per 15 minutes
Massage Therapy:	$40 per half hour, $60 per hour

Financial Policies:

Patients without insurance coverage: **Payment expected at time of service**

Patients with Insurance coverage: **All co-payments are expected at time of service (Other insurance information is listed below.)**

Missed appointments or cancellations less than 24 hours in advance, may be charged a $30 fee.

If you are billed for an outstanding balance and it isn't paid within 30 days, a late fee of 1.5% per month (18% per year) may apply.

Insurance Policy:

1. All deductible payments **must** be made prior to submission of insurance claims.
2. Our office will check and verify your insurance coverage in an effort to help you determine exactly what chiropractic coverage is available to you under your policy. This information is not a guarantee of coverage which will be determined when the explanation of benefits is received from your insurance company.
3. All co-payments are payable when service is rendered, or multiple co-payments may be made at the end of each week. A $150 balance must not be exceeded or your care may be terminated.
4. Since from time to time we experience difficulty collecting from insurance companies, our decision to accept insurance assignment my be terminated at any time. We will, of course, give you ample notice and ask that you act on your own behalf by contacting your insurance company.
5. This office cannot promise that your insurance company will pay the usual and customary charges of this office, nor will this office enter ino any dispute with an insurance company over reimbursement or the amount of reimbursement.
6. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will immediately become due and payable by you.
7. When making a health care decision it is important to remember that you, the patient, are ultimately financially responsible for services rendered.

Signature: _____ Date: _____

PATIENT RECORDS AND DOCTOR'S LIEN

TO: ATTORNEY/INSURANCE CARRIER

_____

_____

_____

_____

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my injury/illness which occurred/began on: _____

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said injury/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing him/her for services rendered me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and that this agreement is made solely for said provider's additional protection and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1% per month service charge.

Patient's Signature: _____ Dated: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: _____ Dated: _____

Please sign, retain a copy for your records, and return this copy to us promptly.

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.