Bahnemann Family Chiropractic, PC: Registration and History

1 PATIENT INFORMATION

Date_____

Patient_____

Patient Social Security _____

Address_____

_____

City State Zip

Email_____

Would you like to receive correspondence via e-mail? Y/N

Sex: ☐ M ☒ F Age_____ Birth Date_____

☐ Single ☐ Married ☒ Widowed ☐ Separated ☐ Divorced

Occupation_____

Employer_____

Spouse's name_____

Birthdate_____Occupation_____

Whom may we thank for referring you?_____

_____

2 PAYMENT INFORMATION

__ Auto Insurance Claim __Commercial Insurance
__No Insurance (Self Pay) __Medicare
__Worker's Compensation

If this is a Commercial Insurance Claim, please fill out the following "Assignment and Release" and provide your health insurance card to the receptionist so she can make a copy of the card. We will file the insurance claim for you.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Bahnemann Family Chiropractic, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext._____

Cell_____ Best number to reach you

May we remind you of your next appointment via text msg or e-mail? (Circle one) (Yes) No

If yes, specify info: _____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Phone_____ Alt Ph_____

4 ACCIDENT INFORMATION

Is condition due to an accident? __Y __N Date_____

Type of accident __Auto __Work __Home __Other

To whom have you made a report of your accident?

__Auto Ins __Employer __Work Comp. __Other

Information for Auto Claims Only:

Name of Auto Insurance:_____

Claim #_____Ph #_____

Adjuster's Name:_____

5 ACCIDENT DIAGRAM

NOTICE OF DOCTOR'S LIEN

LIEN AGREEMENT

I do hereby authorize Dr. Kerri Bahnemann, DC to furnish you, _____ Insurance Company, which will be referred to as “my insurance company” throughout this document, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident on _____, in which I was recently involved.

I hereby authorize and direct you, my insurance company to pay directly to said doctor such sums as may be due and owing her for medical service rendered me both by reason of this accident and by reason of any other bills that are due her office, and to withhold such sums from any settlement, judgment or verdict which may be necessary to adequately protect said doctor. I hereby further give a first party lien on my case to Dr. Kerri Bahnemann, DC against any and all proceeds of my settlement, judgment or verdict which I have been treated of injuries in connection therewith.

I hereby direct any attorney to recognize and honor this lien and to pay you directly from the proceeds allocated to me in his attorney trust account at the time he receives them. I have personally served my attorney with a copy of this lien and as principal have put my attorney, as my agent, on notice regarding his responsibility in paying you.

I agree never to rescind this document and understand that a rescission will not be honored by my insurance company. I hereby instruct that in the event another insurance company is substituted or added in this matter, the new insurance, company honor this first party lien as inherent to the settlement and enforceable upon the case as if it were initially executed by them.

I fully understand that I am directly and fully responsible to the said doctor for all medical bills submitted for her for service rendered to me and that this first party lien agreement is made solely for the said doctor's additional protection and in consideration of her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my insurance company does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a regular basis to keep my account current.

DOA: _____ Patient’s Name _____

Claim #: _____ Patient’s Signature _____

The understanding being a representative of the _____Insurance Company of record for the above patient does hereby agree to observe all the terms of the first party lien and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect the said doctor above named and to execute this lien in the first party on behalf of Dr. Kerri Bahnemann, DC.

_____ _____

Date: Insurance Company Representative Signature

Bahnemann, DC Family Chiropractic PC

7610 N Union Blvd #125

Colorado Springs, CO 80920

Bahnemann Family Chiropractic, PC

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.
There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. ***The possibility of such injuries resulting from cervical spine manipulation is extremely remote;***

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.

Musculoskeletal care contributes to your overall wellbeing. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with ___Kerri Bahnemann, BS, DC_ (health care providers name).

Date: _____

Patient signature (or Legal guardian)

Signature of Witness

Print Name

Print Name:

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 not obligated to agree to those restrictions.

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 affect 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. 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 we do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. 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.

8. From time to time we may send you birthday cards or letters use your name on a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do so.

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

_____ _____

Patient Name Date

_____

Patient Signature

Bahnemann Family Chiropractic PC

2024
PATIENT FINANCIAL POLICY

BAHNEMANN FAMILY CHIROPRACTIC, PC

Patient Name / Family: _____

Date completed: _____

Thank you for choosing Bahnemann Family Chiropractic PC as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present an insurance card at their initial visit, and any time there are changes to their insurance company. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with us. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, ***it is the insurance company that makes the final determination of your eligibility and benefits***. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Participating Insurances

- **Blue Shield Federal Plans**
- **Blue Shield of CO & PPO Plans**
- **Medicare Part B**
- **TriWest VA authorized beneficiaries**

Non-Participating Medicare plans accepted

- **Humana**
- **Aetna**
- **Cigna**
- **United Healthcare**

Participating Insurances

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your insurance claims. If you have out of network benefits, they may pay a portion of your billed charges; however, you are ultimately responsible for any charges you incur while under care in our office.

Referrals and Preauthorizations

Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which our practice does not participate, or patients without an insurance card on file with us. It is always the patients' responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Self-pay patients will be required to pay for their initial telemedicine history, in-office examination and treatment at the initial appointment. Payment arrangements are available if needed, and discounts are available ***when paid at time of service***. Please ask to speak with Dr. Bahnemann to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Motor Vehicle Accident (MVA) and Third Party Billing

We will bill your automobile insurance company for bodily injury care. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to report your injury to your insurance to open a medical payment claim. They may send you an accident questionnaire form to be completed by you. If the questionnaire is not returned to your insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

CANCELLATION OF APPOINTMENTS

If it is necessary to cancel a scheduled appointment, we require at least 3 hours advance notice.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 3 hour advance notice.

No-shows: a no-show is when a patient misses an appointment with no notice ***or shows up too late to the appointment to be seen***.
A **$40.00 fee** will be billed to your account for late cancellations and for no-shows.
Repeatedly missing visits jeopardizes your care. For this reason ***after an ESTABLISHED patient has two (2) late cancellations and/or no-shows or a NEW PATIENT has one (1) cancellation or no-show, they will be discharged from the practice.***

Extenuating circumstances will be considered in making this decision when clearly communicated to our office.

COMPLETION OF FORMS POLICY

In order for us to better serve you, we request that you are aware of the following:

Your insurance company will not be billed as insurance companies do not reimburse for the time and judgment that are required to complete these forms. **Please allow 7 business days for completion of forms.**

Payment is required prior to completion of all form(s)

The fee for completion of forms varies from **$20 to $40** depending on time and complexity. This includes summary of care, FMLA paperwork, or disability determinations.

- **Returned Checks**
  The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.

  Medical Record Copies
  Patients or attorneys requesting copies of medical records will be charged:
  - $18.53 for the first ten pages (1-10)
  - $0.85 per page for the next 30 pages (11-40)
  - $0.57 per page for pages 41 and above (41+)
  - $10.00 additional fee for certification of medical records
  - Cost of portable media supplies, if applicable, i.e. CD or flash drive

Minors
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I understand the above-written financial policies and have had opportunity to discuss my concerns or questions, if I had any, to my satisfaction. Furthermore, I agree to abide by these financial policies for any services rendered to me at Bahnemann Family Chiropractic, PC.

_____ _____
Patient or legal guardian Signature *Date*

email: _____ Cell/Home phone: _____

BAHNEMANN FAMILY CHIROPRACTIC, PC RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS AGREEMENT AT ANY TIME.
PATIENTS WILL BE LIABLE FOR THE TERMS OF THEIR MOST RECENTLY SIGNED AGREEMENT.

Motor Vehicle Crash Form

Patient Name: _____ Date: _____

Date of injury/accident: _____ Time of injury: _____ ☐ AM ☐ PM

City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry

Location where crash occurred: _____

Who owns the vehicle in which you were hit? _____

What is the estimated repair damage to your vehicle? $_____

Who made damage estimates on your vehicle? _____

☐ Yes ☐ No Did the police come to the accident scene?

☐ Yes ☐ No Did the police make a written report?

☐ Yes ☐ No Were any traffic citations written for either of the involved parties?
If yes whom and for what: _____

☐ Yes ☐ No Were any photographs taken of the vehicle?

DESCRIBE HOW THE CRASH HAPPENED

_____

COLLISION DESCRIPTION-TYPE

Check all that apply to you. Indicate which type of automobile crash you were involved in:

☐ Single car crash ☐ Two-vehicle crash ☐ Three or more vehicles

☐ Rear-end crash ☐ Side crash ☐ Rollover

☐ Head-on crash ☐ Hit guard rail, tree, object ☐ Ran off the road

☐ Other (Describe):_____

What was your seating position in the vehicle at the time of the crash? _____

DESCRIBE THE VEHICLE YOU WERE IN (If not certain, check unknown)

Model, make, year: _____ ☐ Unknown

DESCRIBE THE OTHER VEHICLE (If not certain, check unknown)

Model, make, year: _____ ☐ Unknown

AT THE TIME OF THE IMPACT YOUR VEHICLE WAS:

☐ Slowing down ☐ Moving at a constant speed ☐ Changing lanes

☐ Stopped ☐ Making a turn ☐ Making a U turn

☐ Gaining speed ☐ Proceeding straight ahead ☐ Other: _____

AT THE TIME OF THE IMPACT THE OTHER VEHICLE WAS:

☐ Slowing down ☐ Moving at a constant speed ☐ Changing lanes

☐ Stopped ☐ Making a turn ☐ Making a U turn

☐ Gaining speed ☐ Proceeding straight ahead ☐ Other: _____

AFTER THE CRASH, CHECK IF YOUR VEHICLE DID THE FOLLOWING:

☐ Kept going straight, not hitting anything ☐ Spun around, not hitting anything

☐ Kept going straight, hitting a vehicle in front ☐ Spun around, hitting another vehicle

☐ Was hit by another vehicle ☐ Hit curb or other object

INDICATE IF YOUR BODY HIT SOMETHING OR WAS HIT BY ANY OF THE FOLLOWING: (Please draw lines from the body regions on the left side and match to the right side.)

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield or side window
Face	Steering wheel
Shoulder	Side of door
Arm/hand	Dashboard
Front chest wall	Knee bolster/glove compartment
Side chest wall	Seatbelt (Lap belt or shoulder harness)
Hip/abdomen	Frame of car near windows
Knee	Roof or top part of vehicle
Leg	Another occupant/animal
Foot	Other: _____

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

☐ Windshield ☐ Seat frame ☐ Knee bolster

☐ Steering wheel ☐ Side-rear window ☐ Side door

☐ Dash ☐ Mirror ☐ Other: _____

ALL TYPES OF COLLISIONS (Indicate those relevant to your case.)

YES	NO	
☐	☐	Did any of the interior front or side structures within your vehicle, such as the side door, dashboard, steering wheel, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door, dash, or interior of your vehicle touch or hit your body during the crash?
☐	☐	Did your body slide under the seatbelt?
☐	☐	Was the door(s) of your vehicle damaged to the point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash? If yes circle: (Side airbag / Front airbag)
☐	☐	Was the frame of your vehicle bent or damaged?

SEATBELT USAGE AND HAND PLACEMENT:

YES NO

☐ ☐ Were you wearing a seatbelt?

☐ ☐ If yes, does your seatbelt have a: ☐ Lap and shoulder strap,

☐ Lap belt only

☐ ☐ Did you have any portion of your seatbelt placed behind your chest, back or shoulder

☐ ☐ Were you holding onto the steering wheel at the time of impact? (Driver only)

If yes, indicate where each hand was positioned (Use time clock face as your reference)

Left hand: ☐ Not on wheel ☐ Yes, hand at _____ o'clock, ☐ Hand elsewhere

Right hand: ☐ Not on wheel ☐ Yes, hand at _____ o'clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY (Answer this section only if you were hit from the rear.)

Describe your vehicle's head restraint system:

☐ Moveable/adjustable head restraint ☐ Fixed, non-moveable head restraint

☐ No headrests in my vehicle ☐ Bench seat in your vehicle without restraint

Please indicate how your <u>head restraint</u> was positioned at the time of the crash (if present)

☐ At the top of the back of your head ☐ Midway height of the back of your head

☐ Lower height of the back of the head ☐ Located at the level of your neck

☐ Level of your shoulder blades

BRUISING AFTER THE CRASH

YES NO

☐ ☐ Did your body have any bruising (areas that were visibly black, red, and/or blue) after the crash?
If yes, indicate where bruising was located on your body and what caused the bruising:

_____

AWARENESS AND BODY POSITION DESCRIPTIONS: *Check all areas that apply to you.*

☐ You were unaware of the impending collision. You did not see or hear brakes prior to impact.

☐ You were unaware of the impending crash and relaxed before the collision.

☐ You were unaware of the impending crash and braced yourself.

☐ Your body, torso, and head were facing straight ahead.

☐ You had your head and/or torso turned at the time of the collision:

☐ Turned left ☐ Turned right

Describe how far you were turned/twisted and why you were turned/what were you doing:

_____

☐ You were leaning forward prior to the collision resulting in a gap between your back and the seatback.

If yes, indicate how far you were leaning and why you were leaning forward:

_____

☐ Your torso/body were positioned normally against the seatback with no gaps due to leaning/twisting.

HOW SOON DID YOU FIRST NOTICE ANY STIFFNESS, SORENESS, OR PAIN AFTER THE CRASH? (Indicate if immediate or if it started in hours/days):

Post-trauma Symptoms Questionnaire

PATIENT INSTRUCTIONS: *It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single mark or several check marks in the appropriate columns for the specific symptom that applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank of the symptom listed below does not apply to you.*

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HRS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS RECENTLY	HAD SIMILAR SYMPTOMS ONE YEAR BEFORE THIS INJURY
Headache/Migraine				
Dizziness				
Tinnitus (Ringing in the ears)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sleep disturbance				
Fatigue				
Anxiety				
Painful or difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Upper arm burning pain				
Arm pain/tingling/numbness				
Wrist/hand/finger/pain/numbness				
Hand or grip weakness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Ribcage pain/soreness				
Breast pain and/or bruising				
Low back pain/soreness/aching				
Hip pain				
Shooting pain down the entire leg				
Pain radiating down upper leg				
Leg numbness/tingling				
Knee Pain				
Ankle/foot pain				
Other:				

Case # _____

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.
An understanding of your health history will help us to determine appropriate care.

FULL NAME _____ DATE _____

AGE _____ RACE _____ GENDER _____ HEIGHT _____ WEIGHT _____

Review of Systems

1. Do you have skin, hair or nail problems: ☐ Yes ☐ No _____
2. Do you have mouth and/or throat problems? ☐ Yes ☐ No _____
3. Do you have nose and/or sinus problems? ☐ Yes ☐ No _____
4. Do you have ear problems? ☐ Yes ☐ No _____
5. Do you have eye problems? ☐ Yes ☐ No _____
6. Do you have chest or lung (breathing) problems? ☐ Yes ☐ No _____
7. Do you smoke? ☐ Yes ☐ No Amount per day _____ How Long? _____
8. Do you have heart and/or blood vessel problems? ☐ Yes ☐ No _____
9. Do you have blood or lymph node problems? ☐ Yes ☐ No _____
10. Do you have digestive problems? ☐ Yes ☐ No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? ☐ Yes ☐ No _____
12. Do you have urinary (including kidney or bladder) problems? ☐ Yes ☐ No _____
13. **Females**, have you had menstrual problems? ☐ Yes ☐ No _____
    Have you ever taken birth control pills? ☐ Yes ☐ No For how long? _____
    Is there any chance that you are currently pregnant? ☐ Yes ☐ No
    Do you have any breast problems? ☐ Yes ☐ No _____
14. Do you have any nervous system diseases and/or mental health problems? ☐ Yes ☐ No _____
15. Do you have any gland and/or hormone problems? ☐ Yes ☐ No _____
16. Do you have allergy or immuity problems? ☐ Yes ☐ No _____
17. Do you have any muscle, tendon or ligament problems? ☐ Yes ☐ No _____
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? ☐ Yes ☐ No _____

Past History

19. List any diseases which you have had in the past, including childhood diseases: _____
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: _____
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? ☐ Yes ☐ No _____
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    _____ Date _____
    _____ Date _____
    _____ Date _____
    _____ Date _____

(OVER PLEASE)

Rev. 7/04

Case # _____

CASE HISTORY
(CONTINUED)

FULL NAME _____ DATE _____

23. Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No _____
24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____

_____

25. Your diet is: ☐ Balanced ☑ Fair ☐ Poor ☐ Excessive ☐ Restricted

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ☐ Yes ☐ No _____

Social History

27. In what position do you usually sleep, and how well? _____

_____

28. Do you exercise on a regular basis? ☐ Yes ☐ No How? _____
29. How do you spend your spare time (hobbies, etc)? _____
30. Do you use: ☐ Caffiene? ☐ Tobacco? ☐ Nicotine? ☐ Recreational Drugs? ☐ Alcohol?
31. Please describe your work.
    Type: ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker
    Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary
    Stress Level ☐ High ☐ Medium ☐ Low

Additional Questions

32. Do you have problems with recurring headaches? ☐ Yes ☐ No _____
33. Are you losing weight without trying? ☐ Yes ☐ No
34. Does your pain wake you up at night? ☐ Yes ☐ No
35. Have you had a change in bowel or bladder habits? ☐ Yes ☐ No _____
36. Have you had a sore that doesn't heal? ☐ Yes ☐ No _____
37. Have you recently had any unusual bleeding or discharge? ☐ Yes ☐ No _____
38. Do you have a thickening/lump in the breast or elsewhere? ☐ ☐ Yes ☐ No _____
39. Do you have indigestion or difficulty swallowing? ☐ Yes ☐ No _____
40. Have you had an obvious change in a wart or mole? ☐ Yes ☐ No _____
41. Do you have a nagging cough or hoarseness? ☐ Yes ☐ No _____
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

_____

43. Please describe your current complaint. In other words, what brought you here? _____

_____

44. Who is your:
    Medical Doctor? _____
    OB/GYN? _____
    Dentist? _____

Case # _____

PATIENT HEALTH SURVEY

FULL NAME _____ AGE _____ DATE _____

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop attacks (collapsing, but not fainting)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

Do you currently have, or could you be, any of the following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
❑ Male ❑ Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs.day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N