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: _____

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

Primary: _____ *ID#:* _____

Secondary: _____ *ID#:* _____

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: _____

Address: _____

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?** _____

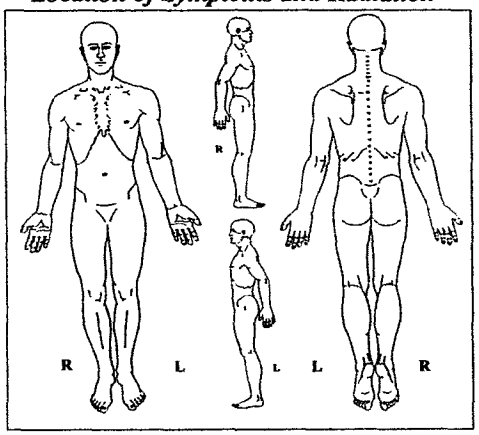
_____

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

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: _____

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ 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:

_____

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

☐ Unknown ☐ Unremarkable

	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								

Family History Comments:

_____

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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

Smoking/Tobacco Use: *If current smoker, amount =* _____

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

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)* _____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: _____
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _____
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: _____
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: _____
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: _____
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

Review of Systems 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)* _____

Assignment of Benefits - Consent Form – Privacy Notice

Patient Name: _____ Date of Birth: _____

SS# or ID#: _____ Group #: _____

I hereby agree to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy with _____ Insurance Company in consideration for treatment rendered by John T. Daniels, D.C. and I hereby instruct them to pay directly by check made out and mailed to: **Daniels Chiropractic, P.C. 2553 S. Colorado Blvd. Ste. 102- Denver, CO 80222**

OR

If my policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make the check out to me and mail it to the above address for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, employer, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Daniels Chiropractic, P.C. this _____ day of _____, 20_____.

_____ _____

Signature of Policy Holder/Claimant **Witness**

CONSENT AND AFFIRMATION

I hereby authorize the doctor and whom ever he may designate as his assistant to administer treatment, physical examination, X-ray studies, chiropractic care or any clinical services he deems necessary in my case. I understand that there are inherent risks associated with chiropractic adjustments, as well as, any medical treatment. I realize that I am ultimately responsible for all expenses incurred for services rendered to me. If x-rays/further testing/exams are suggested by the doctor, but declined by me, the patient, Daniels Chiropractic, P.C. or anyone affiliated with the clinic will not be held responsible. I authorize him to disclose all or any part of my record to any person which may be liable for all or part of the clinic's charge.

By my signature I consent to treatment performed by the doctor and whom ever he designates as his assistant and understand the above information. ***If under 18 years of age, a parent signature is required.***

_____ _____ _____

Patient Signature **(Guardian Signature if necessary)** **Date**

NOTICE OF PRIVACY PRACTICE

This summary discloses how health information about you may be used.

Daniels Chiropractic uses health information about you for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of the care that you receive.

Daniels Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Daniels Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Daniels Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, government function in order to comply with workers compensation laws and regulations.

You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, and revoke your authorization and request an accounting of your health records.

You may complain to Dr. John Daniels and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Daniels Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your health information is used or disclosed, accommodate reasonable requests you may make to communicate with the health information by alternative means or by alternative locations or obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Dr. John Daniels at 720.974.6060.

_____ _____

Patient Signature Date