Chiropractic Case History

Name_____Sex M F Date_____

Address_____City_____State_____Zip_____

H. Phone(_____)_____W. Phone_____ Date of Birth_____ Age_____

Cell Phone (_____)_____ Email Address: _____

Referred by_____Social Security #_____

Occupation_____ Employer_____

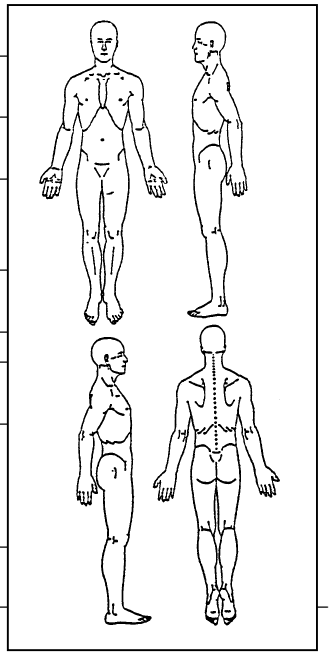
Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____



2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: -
dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____
_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

How frequent is complaint present, how long does it last?_____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____
_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? _____

4. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death

3. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Parent or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

Health Questionnaire

Name: _____

Musculo-Skeletal

- ○ Low back problems
- ○ Pain between shoulders
- ○ Neck problems
- ○ Arm problems
- ○ Leg problems
- ○ Swollen joints
- ○ Painful joints
- ○ Stiff joints
- ○ Sore muscles
- ○ Weak muscles
- ○ Walking problems
- ○ Ruptures
- ○ Broken bones

Genito-Urinary

- ○ Bladder trouble
- ○ Excessive urination
- ○ Scanty urination
- ○ Painful urination
- ○ Discolored urine

Female

- ○ Vaginal discharge
- ○ Vaginal bleeding
- ○ Breast pain
- ○ Lumps on breast
- ○ Pregnant YES / NO

Gastro-Intestinal

- ○ Poor appetite
- ○ Excessive hunger
- ○ Difficult chewing
- ○ Difficult swallowing
- ○ Excessive thirst
- ○ Nausea
- ○ Vomiting food
- ○ Vomiting blood
- ○ Abdominal pain
- ○ Diarrhea
- ○ Constipation
- ○ Black stool
- ○ Bloody stool
- ○ Hemorrhoids
- ○ Liver trouble
- ○ Gall bladder problems
- ○ Weight trouble

Nervous System

- ○ Numbness
- ○ Paralysis
- ○ Dizziness
- ○ Fainting
- ○ Headaches
- ○ Muscle jerking
- ○ Convulsions
- ○ Forgetfulness
- ○ Confusion
- ○ Depression

Cardio-Vascular-Respiratory

- ○ Chest pain
- ○ Pain over heart
- ○ Difficult breathing
- ○ Persistent cough
- ○ Coughing phlegm
- ○ Coughing blood
- ○ Rapid heartbeat
- ○ Blood pressure problems
- ○ Heart problems
- ○ Lung problems
- ○ Varicose veins

Eye, Ear, Nose & Throat

- ○ Eye strain
- ○ Eye inflammation
- ○ Vision problems
- ○ Ear pain
- ○ Ear noises
- ○ Hearing loss
- ○ Ear discharge
- ○ Nose pain
- ○ Nose bleeding
- ○ Nose discharge
- ○ Difficult breathing thru nose
- ○ Sore gums
- ○ Dental problems
- ○ Sore mouth
- ○ Sore throat
- ○ Hoarseness
- ○ Difficult speech

Previous Surgeries: _____

_____

Current Medications: _____

_____

Have you ever received Chiropractic care: YES / NO When: _____ Where: _____

Why: _____

PATIENT PAIN FORM

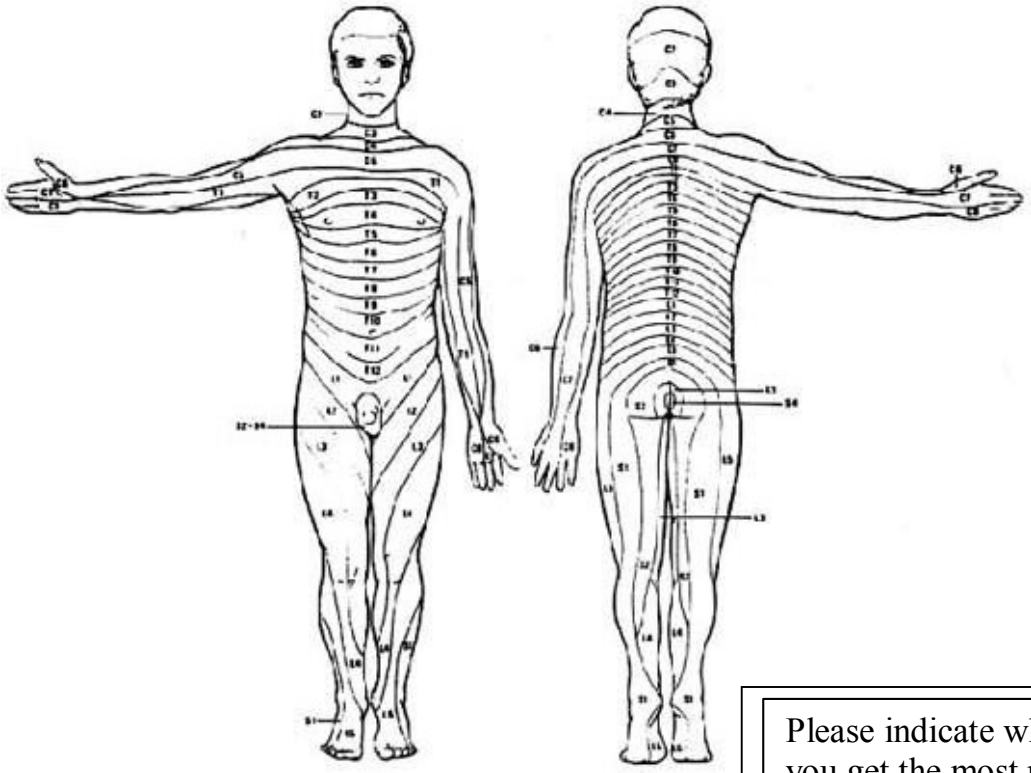
Please circle on this line the level or intensity of pain that you are presently experiencing.

Absolutely _____ Worse pain
Pain Free 1 2 3 4 5 6 7 8 9 10 Imaginable

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

Numbness	Dull Ache	Hot Burning	Sharp/Stabbing	Pins& Needles
= = =	0 0 0	X X X	/ / /	+ + +

(Other discomfort/sensation_____ Use * * *)



Please indicate when you get the most pain. Check one only.

Sitting ?
Standing ?
Lying down ?
Other _____ ?

Signed:_____

Date:_____

Nemanic Chiropractic 4902 E Warner Rd #2 Phoenix AZ 85044, (480) 785-PAIN(7246) (office), (480) 753-5252 (fax)

Specific and Irrevocable Authorization and Assignment of Benefits to Nemanic Chiropractic PLLC

1. I do hereby authorize you to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred at your clinic by me.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney or of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon charges made for your services.

3. I fully understand that my financial obligation to the medical provider above is not contingent on any settlement, claim, judgment or verdict which may be recovered, if there is not recovery, I fully accept responsibility for the debt that I have incurred.

4. I give assignment and lien against any claims against a third party whose negligence may have caused my injury, up to the amount of the bill, for treatment.

5. In the event any insurance company obligated by contractual agreement refuses to make such payment to me or to you for the charges made for your services and refuses the cause of action that exists in my favor against any such company (the names(s) of which is believed to be correctly set forth under pertinent date below) and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to comprise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company(s) contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

6. I waive the Statue of Limitations regarding my doctor's right to recover.

7. As the owner and/or beneficiary of this policy, I further direct that reimbursement of ALL services be paid DIRECTLY to my physician, the provider of services, under the terms of my contract with this company. NO other third party, including any attorney, would receive payment of my medical bills, except the treating physician.

8. I agree never to rescind this document and that a rescission will not be honored by my attorney and/or any insurance carrier. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

9. I waive my confidentiality rights and agree to have my attorney and/or insurance carrier disclose settlement amounts with my provider.

10. The undersigned agrees to be responsible for any fees incurred in the collection of any outstanding balance including attorney fees and/or collection fees. A charge of 25% will be added to your outstanding balance should a collection agencies services become necessary to collect the outstanding balance.

11. I hereby grant Nemanic Chiropractic PLLC, the power to endorse my name upon any checks, drafts, or other negotiable instruments representing payment from any insurance company representing payment for treatment and health care rendered by Nemanic Chiropractic PLLC, I agree that any insurance payment representing an amount in excess for the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to Nemanic Chiropractic PLLC.

Patients'/Guardian's Signature _____Date_____

Print Patient's Name _____Witness Signature_____