CONFIDENTIAL PATIENT CASE HISTORY

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

Name _____ Nickname _____ Birthdate _____ Sex: F M

Address _____ City/State _____ Zip _____

Soc. Sec # _____ Home # _____ Work _____ Cell _____

Marital Status: M D S W Spouse's Name _____

Occupation _____ Employer _____

How did you hear about us? _____ E-mail _____

What is your major complaint? _____

How long have you had this condition? _____

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

What positions make it feel worse? _____

What 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 therapist who have treated THIS condition _____

What do you think caused this condition? _____

What services interest you? (mark all that apply)

☐ balance, coordination training, and strengthening ☐ spinal & body alignment ☐ nutritional & supplement counseling

☐ range of motion, mobility, or flexibility therapy ☐ acupuncture ☐ other: _____

*Female Patients: Is there a possibility you could be pregnant? No Yes Possible Due Date _____

Have you had breast implant surgery? No Yes Do you have a pacemaker? No Yes

Have you had knee or hip replacement surgery? No Yes Describe _____

Do you have any other implantable medical devices in your body? No Yes Describe _____

Do you have a family physician? Name _____

Have you ever been treated by a Chiropractor? No Yes

If yes, by whom? _____ Phone # _____

The reason for the visit: _____

Have you been in an auto accident or had any other personal injury? No Yes Describe _____

_____

In case of emergency, please contact: _____ Relationship _____

Phone # _____

Signature _____ Date _____

DR. DEREK PRICE DR. KARA HOLDEN

Chiropractic Physicians and Certified Acupuncturists

FIRST Chiropractic

1868 HIGHWAY 95
BULLHEAD CITY, ARIZONA 86442

(928) 763-8313
FAX (928) 763-7995

PATIENT NAME: _____ DATE: _____

PREFERRED LANGUAGE: ENGLISH OTHER: _____

RACE:

American Indian or Alaska Native	Native Hawaiian or Pacific Islander
Asian	White
Black or African American	Some Other Race
Hispanic or Latino	Mutli-Racial

CURRENT MEDICATIONS	STRENGTH	FREQUENCY

ALLERGIES ?: YES or NO SEVERITY DESCRIBE REACTION

Medicine: _____ Mild/Moderate/Severe _____

Medicine: _____ Mild/Moderate/Severe _____

Medicine: _____ Mild/Moderate/Severe _____

Medicine: _____ Mild/Moderate/Severe _____

Food: _____ Mild/Moderate/Severe _____

Environmental: _____ Mild/Moderate/Severe _____

SMOKING STATUS (age 13 and over):

Current everyday smoker	Former Smoker
Current someday smoker	Never Smoked

****

The Doctor Checks The Follwing Items:

Height_____ inches_____

Weight_____ pounds_____

Blood Pressure_____/_____

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

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

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

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

NAME _____

Patient Name_____ Number _____ Date _____

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

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

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

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

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

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

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

List any prescription or over-the-counter medications you are currently taking.

Medication	Reason	Medication	Reason
1.		4.	
2.		5.	
3.		6.	

List surgical operations and years: _____

_____

_____

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?_____ Height _____

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

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

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

Smoking ☐ Current ☐ Previous Packs/Day _____ No. of years _____

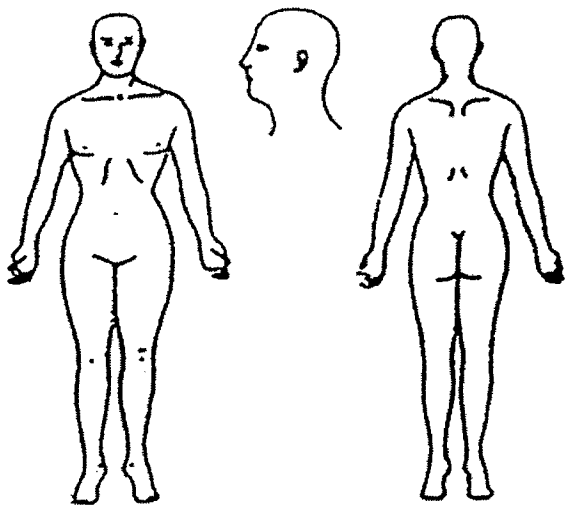
Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

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

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

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 LINES:

How bad are your symptoms now?

None Most Severe

How bad have they been in the past?

None Most Severe

Patient Name_____ Number _____ Date _____

CHOICES FOR PAYMENT IN OUR CLINIC

_____ 1. **CASH AT TIME OF SERVICE**

We do give a discount to people who pay at the time service is rendered. If you choose this option we will not be billing insurance for you. All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

_____ 2. **GROUP HEALTH INSURANCE**

You must pay 100% of your charges until your deductible is satisfied. Once you have satisfied your deductible you will be asked to make a co-payment depending on your policy limits. Once your deductible is met your co-payment will be accepted as payment in full, with the exception of any dispensary products. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

_____ 3. **WORKER'S COMPENSATION**

Your injury must be verified and worker's comp will usually pay 100% of your charges. We will wait for payment on verified claims.

_____4. **PERSONAL INJURY/3RD PARTY CLAIMS**

If you were injured in an accident we will wait to be paid until your claim settles. We will only wait for payment up to one year. You are responsible for payment I full and this service does not release you of your responsibility to pay for the charges.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment, I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. A 40% fee will be added to any balance that is due and turned over to a collection agency.

Patient Name: _____ Date_____

Signature of Patient/Guardian _____

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the the Notice of Privacy Practices of First Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____
Date

_____
Signature

_____
Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

- ☐ Personally ☐ Mail ☐ Phone Follow Up
- ☐ Other: _____

_____
Date

_____
Signature

_____
Print Name of Physician

First Chiropractic
Name of Practice

First Chiropractic
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to First Chiropractic's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority