Required for Your Case History File: All Information Is Confidential

Full Legal Name_____ Name you prefer_____

Mailing Address_____

City_____ State_____ Zip Code_____

Telephone (Home) _____ Telephone (Work) _____

Email _____ Referred by_____

Occupation_____ Employer_____

Name of Spouse_____Number of Children_____

Emergency Contact _____Telephone_____

Age_____ Date of Birth _____ Sex _____ Years of Education_____

Circle one: Married Single Widowed Divorced Separated

Past chiropractic care? Yes ❑ No ❑ If yes, who? _____

Who is your primary care physician? _____
Date of Last Physical Examination_____

Have you been treated for any health condition by a physician in the last year? Yes ❑ No ❑

What medications/vitamins/herbs are you taking?_____
_____
_____Are you allergic to any medications? Yes ❑ No ❑

Previous serious illness/ hospitalization: (Please date & describe) _____
_____

Have ever had: Surgery Yes ❑ No ❑ Fractures Yes ❑ No ❑ Car Accidents Yes ❑ No ❑
Falls Yes ❑ No ❑ On-Job Injury Yes ❑ No ❑

Family history of: Heart disease Yes ❑ No ❑ Cancer Yes ❑ No ❑ Diabetes Yes ❑ No ❑

If you are female, are you possibly pregnant? Yes ❑ No ❑ Date of last menstrual period ____

Primary Symptom/Problem for this visit _____
_____

Have you been prescribed an opioid for your primary problem? Yes ❒ No ❒
Have you had a previous surgery for your primary problem? Yes ❒ No ❒
Are you considering surgery for your primary problem? Yes ❒ No ❒
Have you had a previous steroid injection for your primary problem? Yes ❒ No ❒
Are you considering a steroid injection for your primary problem? Yes ❒ No ❒

Date symptoms first began _____

How did your symptoms first begin? _____

Other Symptoms _____

Pains is: Constant ❑ Intermittent ❑ Is your condition getting? Worse ❑ Better ❑ Same ❑

What activities aggravate your condition?_____

What activities lessen your symptoms? _____

Is condition worse during certain times of the day?_____

Is this condition interfering with work? Yes ❑ No ❑ sleep? Yes ❑ No ❑ routine? Yes ❑ No ❑

Other doctors seen for this condition _____

List home remedies tried _____

Do you have any of the following?

Constitutional
___ Unexplained Weight Loss
___ Fatigue or Weakness
___Fever

Eyes
___Glaucoma
___Cataracts
___Double Vision

Ears, Nose, Throat
___ Difficulty Hearing
___Buzzing or Ringing in Ears
___Dizziness
___ Loss of Smell
___Sinus Trouble
___ Difficulty Swallowing
___Loss of Taste

Skin
___Rashes
___Hives
___Itching

Allergic/Immunologic
___Hives/Hay Fever

Respiratory
___Cold/Flu/Cough
___Coughing Blood
___Wheezing

Gastrointestinal
___Nausea or Vomiting
___Constipation
___Diarrhea
___Digestive Problems

Genitourinary
___Blood in Urine
___Bladder Leakage
___Burning/Frequent Urination

Musculoskeletal
___Spinal Pain
___Joint Swelling
___Joint Stiffness

Cardiovascular
___Chest Pain
___Shortness of Breath
___Racing Heartbeat
___Fainting Spells

Neurological
___Headaches
___Memory Loss
___Tremors
___Numbness
___Loss of Strength
___Seizures

Mental Status
___Anxiety/Depression
___Mood Swings
___Difficult Sleeping
___Stress

Endocrine
___Loss of Hair
___Heat/Cold Intolerance
___Diabetes
___Excessive Sweating
___Change in Appetite

Hematologic/Lymphatic
___Ease of bruising
___Gums Bleed Easily
___Enlarged Glands

Check if you have had any of the following symptoms in the last 30 days:

Pain worse at night ❑ Constant pain unrelated to motion ❑ Unexplained weight loss ❑
Loss of bowel or bladder control ❑ Bacterial infection ❑ Surgery ❑ Fever or chills ❑

Check if you have ever had any of the following:

History of Cancer ❑ History of HIV ❑ Use of Steroids ❑ Use of IV Drugs ❑ Blood Transfusions ❑

*NOTICE TO NEW PATIENTS: Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. In the event of my default, I promise to pay legally allowed interest on my indebtedness, together with collection costs and reasonable attorney's fees. I authorize the release of any information you deem appropriate to any insurance company.

Signature _____Date _____form 105 a

ACCIDENT INFORMATION

DATE OF ACCIDENT_____ HOUR _____ AM or PM

LOCATION_____

HOW DID ACCIDENT OCCUR? _____

_____

HAVE YOU LOST ANY DAYS OF WORK? (HOW MANY AND DATES)
_____

HAVE YOU EVER HAD SIMILAR ACCIDENTS OR
INJURIES?_____

_____

NAME OF ANY WITNESS _____

ACCIDENT REPORTED TO _____

INSURANCE COMPANIES INVOLVED:

YOUR HEALTH INSURANCE CO. _____

ADDRESS _____ POLICY NO. _____

*YOUR OTHER INSURANCE CO.*_____ *POLICY NO.* _____

ADDRESS _____ PHONE _____

ADJUSTER _____

OTHER PARTY'S INSURANCE CO. _____ *POLICY NO.* _____

ADDRESS _____PHONE _____

ADJUSTER _____

HAS AN ATTORNEY ADVISED YOU ON THIS MATTER? YES ❒ NO ❒

IF SO, NAME _____ PHONE _____

ADDRESS _____

If Car Accident:

YEAR, MAKE, MODEL OF YOUR CAR___________________________________

YEAR, MAKE, MODEL OF OTHER CAR__________________________________

WERE YOU STRUCK FROM: BEHIND ❒ RIGHT SIDE ❒ LEFT SIDE ❒

FRONT ❒

WERE YOU MOVING? YES ❒ NO ❒ IF YES, APPROXIMATE SPEED________

WERE YOUR BRAKES APPLIED? YES ❒ NO ❒

TYPE OF TRANSMISSION? STANDARD ❒ AUTOMATIC ❒

WERE YOU THE DRIVER OR A PASSENGER?_____________________________

OTHER PERSONS IN THE CAR ____

WERE YOU USING? SEAT BELT ❒ SHOULDER HARNESS ❒ NOTHING ❒

HEAD RESTRAINT ON YOUR SEAT? YES ❒ NO ❒

ROAD CONDITIONS? WET ❒ DRY ❒ SNOW ❒ ICE ❒

POSITION OF HEAD AT IMPACT?_______________________________________

POSITION OF HANDS AT IMPACT?_____________________________________

WAS THE AIR BAG DEPLOYED? YES ❒ NO ❒

WERE YOU AWARE OF THE IMPENDING COLLISION? YES ❒ NO ❒

DID YOU STRIKE ANYTHING INSIDE THE CAR? YES ❒ NO ❒

DESCRIBE____

DID YOU FEEL MORE THAN ONE IMPACT? YES ❒ NO ❒ UNCERTAIN ❒

DESCRIBE____

WERE YOU UNCONSCIOUS? YES ❒ NO ❒ UNCERTAIN ❒

DESCRIBE____

WERE YOU DAZED? YES ❒ NO ❒ UNCERTAIN ❒

WHEN DID THE PAIN OR DISCOMFORT BEGIN? __________________________

WHERE DID YOU GO AFTER THE ACCIDENT?_____________________________

IF HOSPITAL, WHAT WAS DONE THERE?__________________________________

WAS A POLICE REPORT MADE? YES ❒ NO ❒

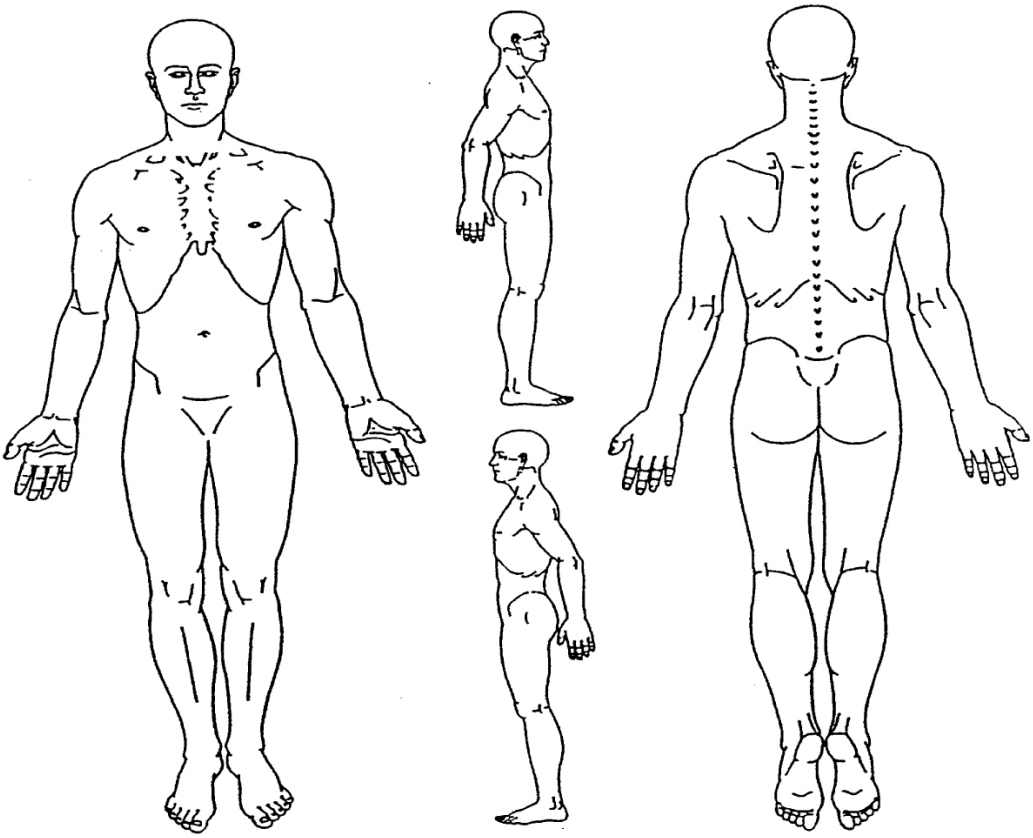
OFFICIAL ESTIMATED PROPERTY DAMAGE? $_______________________

****

SIGNATURE _____________________________ DATE _____________________

Where is your pain now? Mark the areas where you feel sensations using the appropriate symbols. Please mark an X on the area where the pain is now worst.

Aching	Numbness	Pins and Needles	Burning	Sharp/stabbing	Stiff/tight
yyyyy	= = =	oooo	zzzz	/////	***



How bad is your pain? On the scale below circle your pain.

Right now..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
On average..... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
At its very worst... No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Overall, is your pain generally: improving ❑ same ❑ worsening ❑

Name _____ Date_____

form 102

Screening Questionnaire

Please read and answer each item carefully. Circle only one answer for each item.

1. When I am in pain I feel I can't stand it anymore.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

2. When I am in pain it is awful and I feel that it overwhelms me.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

3. When I am in pain I become afraid that the pain will get worse.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

4. When I am in pain I wonder whether something serious may happen.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

5. When I am in pain I keep thinking about how much it hurts.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

6. When I am in pain I can't seem to keep it out of my mind.

0	1	2	3	4
not at all	to a slight degree	to a moderate degree	to a great degree	all the time

7. In general, how satisfied are you with your job?

0	1	2	3	4
completely satisfied	satisfied	neither satisfied or dissatisfied	dissatisfied	completely dissatisfied

8. During the past month:

Have you often been bothered by feeling down, depressed, or hopeless? Yes No

Have you often been bothered by little interest or pleasure in doing things? Yes No

9. Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Patient's Signature_____ Date_____

PATIENT _____

Family Health History

DATE _____

Relation	Age	First Name Only	If Deceased Cause of Death	Age At Death	State of Health
Father					
Mother					
Husband or wife					
Brothers and Sisters					
Children					
Others					

form 106

HEALTH INSURANCE FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to understand our financial policy.

Most health and accident insurance companies cover chiropractic care. Keep in mind that your insurance policy is a contract between you and your insurance company.

If you have insurance, we will call your insurance company to determine your coverage for chiropractic care. However, information provided by phone (or written in an insurance policy book) does not guarantee the payment of benefits. Insurance companies cannot establish whether benefits will be paid until an actual claim is submitted. We cannot take responsibility for knowing which services your insurance company will or will not cover. Not all insurance plans cover all services. Ultimately, you are the party responsible for payment for all health care services we provide to you at our clinic. As a courtesy to you, we will gladly submit to your insurance company invoices for services we provide to you.

PAYMENT RESPONSIBILITY
I understand that I am personally responsible for any remaining balance this clinic does not collect from my insurance company. In the event my insurance company does not compensate your clinic within sixty (60) days after billing, I will pay the remaining balance.

I have read and understand this financial policy and agree to be bound by its terms.

_____ Date _____
Signature of patient (or responsible party, if minor)

_____
Please print the name of the patient

HOWARD COUNTY
CHIROPRACTIC
SPINE & SPORTS REHABILITATION

MEDICAL REPORTS AND DOCTOR'S LIEN

I hereby authorize the above named doctor and his clinic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment and prognosis of me in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay to said doctor such sums as may be due and owing him for medical services rendered to me by reason of this accident that are due his office by withholding such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor, and paying such doctor said sums. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to me or to you, my attorney, on my behalf, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document. 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 were executed by him. I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney 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 current basis.

Dated _____ Patient's Signature _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect said doctor above-named.

Dated _____ Attorney's Signature _____

Please date, sign and return one copy to doctor's office. Keep one copy for your records.

HOWARD COUNTY
CHIROPRACTIC
SPINE & SPORTS REHABILITATION

SCHEDULE OF FEES FOR PROFESIONAL SERVICES
ACTIVE CARE

OFFICE VISIT EXAMS - NEW PATIENT

Initial Consultation	No Fee
Brief Exam (99202)	$83.00
Low/Moderate Exam (99203)	$127.00
Moderate Exam (99204)	$173.00
Comprehensive Exam (99205)	$232.00

OFFICE VISIT EXAMS - DOCTOR REFERRED NEW PATIENT

Brief Exam/Consult (99242)	$123.00
Low/Mod Exam/Consult (99243)	$167.00
Moderate Exam/Consult (99244)	$213.00

OFFICE VISIT EXAMS - ESTABLISHED PATIENT

Brief Exam (99211)	$47.00
Low/Moderate Exam (99212)	$73.00
Moderate Exam (99213)	$112.00
Comprehensive Exam (99214)	$153.00

PHYSICAL MEDICINE

98940*	CMT; 1-2 spinal regions	$52.00
98941*	CMT; 3-4 spinal regions	$57.00
98942*	CMT; 5 spinal regions	$68.00
97012	Mechanical Traction	$33.00
97140	Manual Therapy	$53.00
97110	Therapeutic Exercise	$37.00
97530	Therapeutic Activity	$37.00
97799	Dry Needling	$27.00
97799	Kinesio Tape Application	$21.00

*Covered By Medicare

I have read and understand the Fee Schedule on this paper and agree to it in whatever prescription the Doctor advises in my best interest.

Patient's Name (Printed) _____ Patient's Signature (or representative) _____ Date _____

Howard County Chiropractic
Acknowledgement of Receipt of Notice

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this clinic's Notice of Privacy Practices which has an effective date of April 14, 2003.

Patient Name (print) _____

Patient Signature _____

Date _____

If signed by someone other than the patient, please indicate:

Relationship: ❒ parent or guardian of minor patient
❒ guardian or conservator of an incompetent patient
❒ beneficiary or personal representative of deceased patient
❒ other (specify)

For Office Use Only

Photo ID Date _____ Initial _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❒ Individual refused to sign

Signature of witness _____

Printed name of witness _____

Date _____