Chiropractic Case History/Patient Information

Date:__________________ *Patient #*___________ **Doctor:**___________________

*Name:*_________________________ *Social Security #*_________________*Home Phone:* _______________

*Address:*___________________________________*City:*___________________ *State:*_____ *Zip:*___________

*E-mail address:*____________________________*Fax #*_________________ *Cell Phone:*__________________

*Age:*_______ *Birth Date:*___________ *Race:*______ *Marital: M S W D*

*Occupation:*_________________________ *Employer:*____

*Employer's Address:*__________________________________ *Office Phone:*_____________________________

*Spouse:*___________________ *Occupation:*________________ *Employer:*__________________________________

*How many children?*____________*Names and Ages of Children:*_______________________________________

____

*Emergency Contact (relationship to you?)*______________________________ *Phone:*____________________

*How were you referred to our office?*____

*Family Medical Doctor:*____

*When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?*___________

Please check any and all insurance coverage that may be applicable in this case:

π *Major Medical* π *Worker's Compensation* π *Medicaid* π *Medicare* π *Auto Accident*
π *Medical Savings Account & Flex Plans* π *Other*

*Name of Primary Insurance Company:*____
*Name of Secondary Insurance Company (if any):*____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information:

____

____

*Patient's Signature:*____ *Date:*________________

*Guardian's Signature Authorizing Care:*________________________________ *Date:*________________

PATIENT NAME ____

DATE ____________________ Doctor__________________________

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:____

Date symptoms appeared or accident happened:____

Is this due to: Auto___ Work____ Other____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:______________

____

Days lost from work:_________________ Date of last physical examination:_________________________

Do you have a history of stroke or hypertension?____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

____

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

If yes, describe:____

What medications or drugs are you taking?____

____

Do you have any allergies to any medications? π Yes π No

If yes, describe:____

Do you have any allergies of any kind? π Yes π No

If yes, describe:____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe ______________________________

Women: Are you pregnant?___________________

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** *if you have these conditions* **now** *or* **P** *if you have had these conditions* **previously***.*

N = Now P = Previously

Headaches______ Frequency	*_________*	*Loss of Balance*	*___________*
Neck Pain	*_________*	*Fainting*	*___________*
Stiff Neck	*_________*	*Loss of Smell*	*___________*
Sleeping Problems	*_________*	*Loss of Taste*	*___________*
Back Pain	*_________*	*Unusual Bowel Patterns*	*___________*
Nervousness	*_________*	*Feet Cold*	*___________*
Tension	*_________*	*Hands Cold*	*___________*
Irritability	*_________*	*Arthritis*	*___________*
Chest Pains/Tightness	*_________*	*Muscle Spasms*	*___________*
Dizziness	*_________*	*Frequent Colds*	*___________*
Shoulder/Neck/Arm Pain	*_________*	*Fever*	*___________*
Numbness in Fingers	*_________*	*Sinus Problems*	*___________*
Numbness in Toes	*_________*	*Diabetes*	*___________*
High Blood Pressure	*_________*	*Indigestion Problems*	*___________*
Difficulty Urinating	*_________*	*Joint Pain/Swelling*	*___________*
Weakness in Extremities	*_________*	*Menstrual Difficulties*	*___________*

PATIENT NAME ____

DATE ____________________ *Doctor__________________________*

Breathing Problems	________	*Weight Loss/Gain*	__________
Fatigue	________	*Depression*	__________
Lights Bother Eyes	________	*Loss of Memory*	__________
Ears Ring	________	*Buzzing in Ears*	__________
Broken Bones/Fractures	________	*Circulation Problems*	__________
Rheumatoid Arthritis	________	*Seizures/Epilepsy*	__________
Excessive Bleeding	________	*Low Blood Pressure*	__________
Osteoarthritis	________	*Osteoporosis*	__________
Pacemaker	________	*Heart Disease*	__________
Stroke	________	*Cancer*	__________
Ruptures	________	*Coughing Blood*	__________
Eating Disorder	________	*Alchoholism*	__________
Drug Addiction	________	*HIV Positive*	__________
Gall Bladder Problems	________	*Depression*	__________
Ulcers	________		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

__________ *Vigorous Exercise*

__________ *Moderate Exercise*

__________ *Alcohol Use*

__________ *Drug Use*

__________ *Tobacco Use*

__________ *Caffeine*

__________ *High Stress Activity*

_________ *Family Pressures*

_________ *Financial Pressures*

_________ *Other Mental Stresses*

_________ *Other (specify)______*

____

____

LAST PHYSICAL EXAM__________________

HOW WELL DO YOU SLEEP AT NIGHT?

____

____

____

CONDITION	*FATHER Age [ ]*	*MOTHER Age [ ]*	*SPOUSE Age [ ]*	*BROTHER(S) Age [ ] Age [ ]*	*SISTERS Age [ ] Age [ ]*	*CHILDREN Age [ ] Age [ ]*
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

PATIENT NAME ____

DATE ____________________ *Doctor*__________________________

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient ____

Signature of Patient/Legal Guardian ____

Date ____

INFORMED CONSENT
TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me, ______________________________ by Brian J. Wirth, D.C. and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Brian J. Wirth, D.C. and/or other licensed Physician of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Wirth and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of all healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

____

Please Print Your Name

____

Please Sign Your Name

INFORMED CONSENT
TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on the patient named below, for whom I am legally responsible: ___________________________ by Brian J. Wirth, D.C. and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Brian J. Wirth, D.C. and/or other licensed Physician of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Wirth and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of all healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient's representative, if necessary, (e.g. If the patient is a minor or is physically or mentally incapacitated)

____

Print Name of Patient

____

Relationship to Patient

____

Signature of Representative

WIRTH CHIROPRACTIC

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information. We may have to disclose your health information to another care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of you health condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. We may need to use your health information within our practice for quality control or other operational purposes.

We have a complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time, however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

______________________________	______________________________
Patient Name (Print)	Date
______________________________	Dr. Brian Wirth
Patient Signature	Authorized Provider Representative

WIRTH CHIROPRACTIC
303 Plaza Drive
Greenville, NC 27858
Dr. Brian J Wirth

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you by phone, e-mail, cards, or letters with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information. We may post your name on our bulletin board to thank you for any patient referrals that you make to our office.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time. (164-524)

This notice is effective as of ________________________. This information will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

___________________________	___________________________
Patient Name (Printed)	Date
___________________________	___________________________
Patient Signature	Auth. Provider Signature
	___________________________
	Personal Representative Sign.

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_________________________________ Date_______________

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of _______________________, 20___

By____________________________________

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____________________________________

Signature of Parent/Guardian (circle one)

X-RAY CONSENT

Wirth Chiropractic
303 Plaza Dr.
Greenville, NC 27858
1-800-BACK- DOC

I ________________________ (name of person being treated) hereby acknowledge that Dr. Brian Wirth of Active Living Chiropractic has informed me of the advisability of, risk, inherent in, and the probable consequences of X-rays. He has explained to me the reasons and need for such x-rays. With my understanding I am giving Dr. Brian Wirth my consent to take X-rays.

Date________________

Patient Signature____________________