

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:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans 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 _____
 Neck Pain _____
 Stiff Neck _____
 Sleeping Problems _____
 Back Pain _____
 Nervousness _____
 Tension _____
 Irritability _____
 Chest Pains/Tightness _____
 Dizziness _____
 Shoulder/Neck/Arm Pain _____
 Numbness in Fingers _____
 Numbness in Toes _____
 High Blood Pressure _____
 Difficulty Urinating _____
 Weakness in Extremities _____

Loss of Balance _____
 Fainting _____
 Loss of Smell _____
 Loss of Taste _____
 Unusual Bowel Patterns _____
 Feet Cold _____
 Hands Cold _____
 Arthritis _____
 Muscle Spasms _____
 Frequent Colds _____
 Fever _____
 Sinus Problems _____
 Diabetes _____
 Indigestion Problems _____
 Joint Pain/Swelling _____
 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	_____	Alcoholism	_____
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	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify) _____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	

LAST PHYSICAL EXAM _____

HOW WELL DO YOU SLEEP AT NIGHT?

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	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.

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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 your 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

Patient Signature

Dr. Brian Wirth
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 _____

Wirth Chiropractic

303 Plaza Drive

Greenville, NC 27858

Name _____ Date _____ Chart# _____

- What was the date of the accident? _____
- What time did the accident occur? _____
- How many vehicles were involved in the accident? _____
- What was the estimated damage to the vehicle you were in? _____
- What state did the accident occur in? _____
- What city did the accident occur in? _____
- What street or intersection were you on when the accident occurred? _____
- What direction were you traveling in? _____
- What type of impact was the auto accident? _____
- Did your vehicle hit anything after the accident? If yes, please describe

- Where were you sitting in the vehicle during the accident?

- Did you know the accident was coming? _____
- What type of vehicle were you in? _____
- What type of vehicle impacted yours? _____
- At the time of the impact, how fast was your vehicle moving? _____
- At the time of the impact, how fast was the other vehicle moving? _____

- During and after the crash what happened to your vehicle? (Circle all that apply)

-kept going straight
-kept going straight hitting a car in front
-was hit by another vehicle

-spun around
-spun around and hit a stationary object
-hit a stationary object

18. Did you lose consciousness during the accident? -Yes -No

19. How was your head positioned during the accident? _____

20. How were your hands positioned during the accident? _____

21. Did your head hit anything during the accident? -No -Yes, please describe _____

22. Did your face hit anything during the accident? -No -Yes, please describe _____

23. Did your shoulders hit anything during the accident? -No -Yes, please describe _____

24. Did your neck hit anything during the accident? -No -Yes, please describe _____

25. Did your chest hit anything during the accident? -No -Yes, please describe _____

26. Did your hips hit anything during the accident? -No -Yes, please describe _____

27. Did your knees hit anything during the accident? -No -Yes, please describe _____

28. Did your feet hit anything during the accident? -No -Yes, please describe _____

29. Did you have your seatbelt on during the accident? -No -Yes

30. Did you slide out of your seatbelt during the accident? -No -Yes

31. What was damaged on your vehicle? (Circle all that apply)

-windshield
-steering wheel
-dashboard
-seat frame
-side window
-rear window

-rear bumper
-front bumper
-trunk
-front left door
-front right door

-mirror
-knee bolster
-back right door
-completely totaled
-back left door

32. Choose the items that dented inward

-floorboards -side door -dashboard

33. Choose the doors that would not open as a result of the accident

-front left -front right
-rear left -rear right

34. Did you go to the hospital? -Yes -If No, why and do not answer 35-40

35. How did you get to the hospital? _____

36. What was the name of the hospital? _____

37. Were you hospitalized over night? _____

38. Circle what you were prescribed at the hospital

-pain medication -muscle relaxers -neck brace

39. Did you receive any stitches for any cuts at the hospital? –Yes -No

40. Were any x-rays taken at the hospital? If yes, which area was taken?

Wirth Chiropractic
303 Plaza Dr.
Greenville, NC 27858
Phone: 1-800-BACK-DOC
Fax: 252-756-6904
Dr. Brian Wirth

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

IN CONSIDERATION of the willingness of Active Living Chiropractic to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign to Active Living Chiropractic any proceeds or compensation that I am or may become entitled to receive as a result of injuries that occurred on

_____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Active Living Chiropractic, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgments, settlements, or proceeds of any kind that would otherwise be payable to me, such sums as are due to Active Living Chiropractic for its services rendered.

I appoint Active Living Chiropractic as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am a named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Active Living Chiropractic .

I authorize Active Living Chiropractic to release to any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Active Living Chiropractic for services rendered, including any balance remaining after the application of insurance payments and settlement or judgment proceeds. If Active Living Chiropractic is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Active Living Chiropractic for its costs of recovery, including reasonable attorney's fees.

I further agree this assignment of benefits (AOB) cannot be revoked and the right to receive payment cannot be transferred to any other party or re-asserted by me in any way.

Patient

Parent/Guardian

Date

Witness

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Active Living Chiropractic hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-named patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Active Living Chiropractic hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Active Living Chiropractic agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

Patient: _____ Date: _____
Parent/Guardian: _____ Date: _____