

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: ☐ Male ☐ Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - Home, Mobile, or Work ☐ Other: \_\_\_\_\_

\*Referred By: (Name) \_\_\_\_\_

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: \_\_\_\_\_

## Race & Ethnicity: (Choose up to 2)

- ☐ African American or Black  
☐ American Indian or Alaskan Native  
☐ Asian  
☐ Hispanic or Latino  
☐ Native Hawaiian or Other Pacific Islander  
☐ White  
☐ Decline

## Preferred Language:

- ☐ English  
☐ Spanish  
☐ Other: \_\_\_\_\_  
☐ Decline

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

## FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: \_\_\_\_\_

Will we be working with insurance? ☐ No ☐ Yes (Details)

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

Where would you like statements sent?

☐ Self ☐ Other (Details below)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

Account No: \_\_\_\_\_

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: \_\_\_\_\_

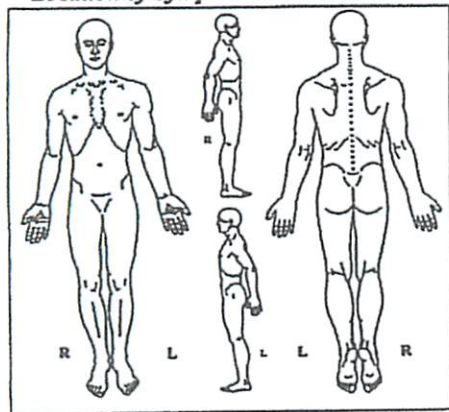
Secondary Complaints: \_\_\_\_\_

When did it start? \_\_\_\_/\_\_\_\_/\_\_\_\_ What happened? \_\_\_\_\_

Which daily activities are being affected by this condition? \_\_\_\_\_

## MAJOR COMPLAINT

### Location of Symptoms and Radiation



P \_\_ Pain  
N \_\_ Numb  
S \_\_ Spasm  
T \_\_ Tender  
H \_\_ Hypoesthesia

### Grade Intensity/Severity:

- ☐ None (0/10)  
☐ Mild (1-2/10)  
☐ Mild-Moderate (2-4/10)  
☐ Moderate (4-6/10)  
☐ Moderate-Severe (6-8/10)  
☐ Severe (8-10/10)

### Frequency:

- ☐ Off & On  
☐ Constant

### Quality:

- ☐ Sharp  
☐ Stabbing  
☐ Burning  
☐ Achy  
☐ Dull  
☐ Stiff & Sore  
☐ Other: \_\_\_\_\_

### Does it radiate?

- ☐ No ☐ Yes (Please indicate on drawing)

### Improves with:

- ☐ Ice  
☐ Heat  
☐ Movement  
☐ Stretching  
☐ OTC Medications: \_\_\_\_\_  
☐ Other: \_\_\_\_\_

### Worsens with:

- ☐ Sitting  
☐ Standing/Walking  
☐ Lying Down/Sleeping  
☐ Overuse/Lifting  
☐ Other: \_\_\_\_\_

### Previous Treatment:

- ☐ None  
☐ Chiropractor \_\_\_\_\_  
☐ Medical Doctor \_\_\_\_\_  
☐ Physical Therapy \_\_\_\_\_  
☐ ER/Urgent Care \_\_\_\_\_  
☐ Orthopedic \_\_\_\_\_  
☐ Other: \_\_\_\_\_

### Previous Diagnostic Testing:

- ☐ None  
☐ X-rays \_\_\_\_\_  
☐ MRI \_\_\_\_\_  
☐ CT \_\_\_\_\_  
☐ Other: \_\_\_\_\_

### \*Women: Are you pregnant?

- ☐ No Last Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Yes Due date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Present Illness Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Prescription Medications & Supplements: ☐ None

☐ Yes (List - Name, dosage, frequency) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Allergies to Medications: ☐ No known drug allergies

☐ Yes (List - Name and reaction) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# PAST, FAMILY, AND SOCIAL HISTORY

## PAST MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply and use comments to elaborate.)

### Illnesses:

- ☐ Asthma  
☐ Autoimmune Disorder (type) \_\_\_\_\_  
☐ Blood Clots  
☐ Cancer (type) \_\_\_\_\_  
☐ CVA/TIA (stroke)  
☐ Diabetes  
☐ Migraine Headaches  
☐ Osteoporosis  
☐ Other: \_\_\_\_\_

### Injuries:

- ☐ Back Injury  
☐ Broken Bones  
☐ Head Injury  
☐ Neck Injury  
☐ Falls  
☐ Other: \_\_\_\_\_

### Hospitalizations: (Non-surgical with Date)

### Surgeries: (If yes, provide type & surgery date)

- ☐ Cancer  
☐ Orthopedic  
     Shoulder - R / L \_\_\_\_\_  
     Elbow/Forearm - R / L \_\_\_\_\_  
     Wrist/Hand - R / L \_\_\_\_\_  
     Hip - R / L \_\_\_\_\_  
     Knee - R / L \_\_\_\_\_  
     Ankle/Foot - R / L \_\_\_\_\_  
☐ Spinal Surgery  
     Neck: \_\_\_\_\_  
     Back: \_\_\_\_\_  
☐ Other: \_\_\_\_\_

### Medical History Comments:

## FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- ☐ Unknown    ☐ Unremarkable

### Family History Comments:

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

## SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: \_\_\_\_\_

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: \_\_\_\_\_

Employed: ☐ No ☐ Yes (Occupation) \_\_\_\_\_

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: If current smoker, amount = \_\_\_\_\_

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

### Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

### Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: \_\_\_\_\_



## REVIEW OF SYSTEMS

**Are you *currently* experiencing any of these symptoms?** (Please select all that apply and use comments to elaborate.)

☐ Fever  
☐ Fatigue  
☐ Other: \_\_\_\_\_  
☐ None in this Category

☐ Joint Pain/Stiffness/Swelling  
☐ Muscle Pain/Stiffness/Spasms  
☐ Broken Bones \_\_\_\_\_  
☐ Other: \_\_\_\_\_  
☐ *None in this Category*

☐ Dizziness or Lightheaded  
☐ Convulsions or Seizures  
☐ Tremors  
☐ Other: \_\_\_\_\_  
☐ None in this Category

- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: \_\_\_\_\_
- ☐ *None in this Category*

- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: \_\_\_\_\_
- ☐ *None in this Category*

- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: \_\_\_\_\_
- ☐ *None in this Category*

- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: \_\_\_\_\_
- ☐ *None in this Category*

☐ Difficulty Breathing  
☐ Cough  
☐ Other: \_\_\_\_\_  
☐ *None in this Category*

☐ Eye Pain  
☐ Blurred or Double Vision  
☐ Sensitivity to Light  
☐ Other: \_\_\_\_\_  
☐ *None in this Category*

☐ Frequent or Recurrent Headaches  
☐ Ear - Ache/Ringing/Drainage  
☐ Hearing Loss  
☐ Sensitivity to Loud Noises  
☐ Sinus Problems  
☐ Sore Throat  
☐ Other: \_\_\_\_\_  
☐ *None in this Category*

☐ Infertility  
☐ Recent Weight Change  
☐ Eating Disorder  
☐ Other: \_\_\_\_\_  
☐ None in this Category

☐ Excessive Thirst or Urination  
☐ Cold Extremities  
☐ Swollen Glands  
☐ Other: \_\_\_\_\_  
☐ *None in this Category*

- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: \_\_\_\_\_
- ☐ *None in this Category*

☐ Food Allergies  
☐ Environmental Allergies  
☐ Other: \_\_\_\_\_  
☐ *None in this Category*

This image shows a single page of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

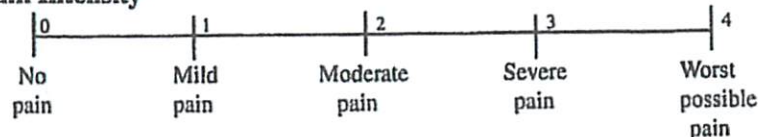
Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Functional Rating Index

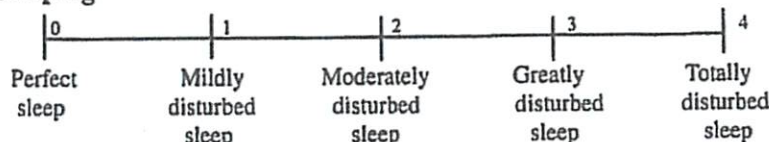
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

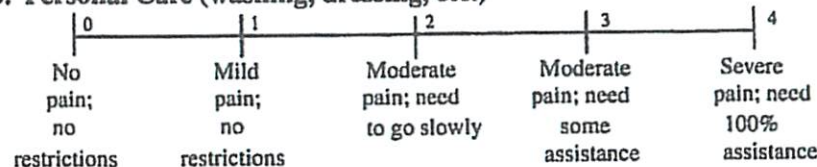
## 1. Pain Intensity



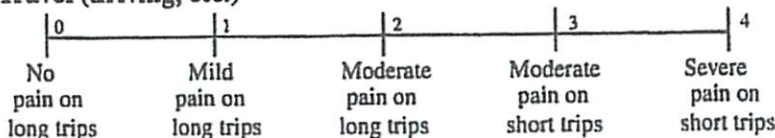
## 2. Sleeping



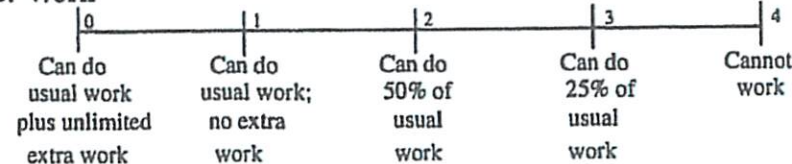
## 3. Personal Care (washing, dressing, etc.)



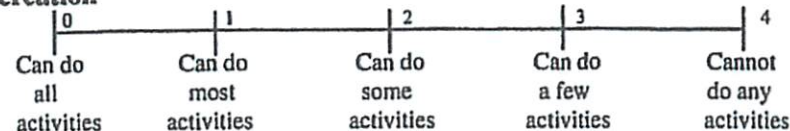
## 4. Travel (driving, etc.)



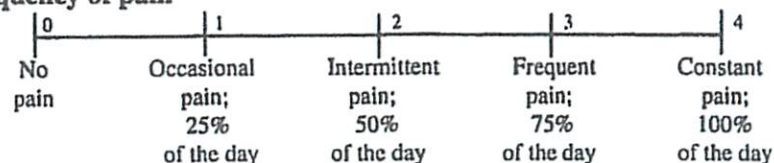
## 5. Work



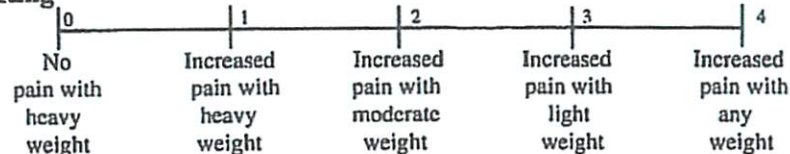
## 6. Recreation



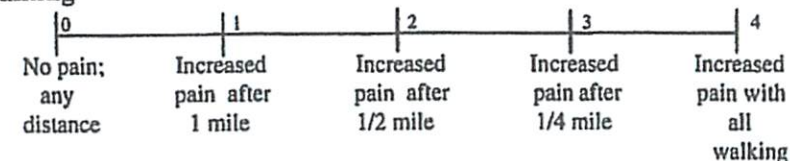
## 7. Frequency of pain



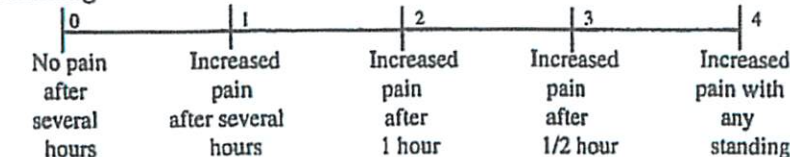
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

PRINTED

Signature

Total Score \_\_\_\_\_

Date



# Harley Chiropractic, LLC

**Patient Name:**  
**Patient D.O.B.:**  
**Patient Number:**

## *Informed Consent for Chiropractic Services*

**I have been informed of the following:**

1. I have been informed that the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
2. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
3. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury;
4. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
5. I have been informed that certain techniques may require close proximity between clinician and patient;
6. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations;
7. I have been informed that it is my responsibility to inform the chiropractor of any condition(s) that would otherwise not come to their attention;
8. I have been informed that the chiropractor has made no guarantee of a positive outcome from treatment; and
9. I have been afforded ample opportunity for questions and answers.

## **Therefore, by signing below:**

**I consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

**I consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Name (if applicable): \_\_\_\_\_

Guardian Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Harley Chiropractic, LLC

**ACKNOWLEDGEMENT:** We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail, text and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. **Biometrics:** Harley Chiropractic may securely store biometrics to utilize software to streamline the check-in process and better serve its patients, however, these biometrics are never shared or sold.

**ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:** By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arrangement between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

**CMS-1500 HEALTH INSURANCE CLAIM FORM:** By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

**AUTHORIZATION:** The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms. Radiographs (X Rays) may be taken or ordered to further the Chiropractor's understanding of the underlying condition, positions and alignment of the spine and associated structures. There is limited risk from radiation exposure.

If you are or think you may be pregnant alert the Chiropractor and/or X ray lab technician.

Therefore, by signing below:

**I ACKNOWLEDGE** THAT I HAVE BEEN OFFERED A COPY OF: *NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.*

**I CONSENT** TO THE PERFORMANCE OF THE ABOVE-MENTIONED PROCEDURES PERFORMED BY THE DOCTOR AND/OR STAFF INVOLVED IN MY CASE:

**I ACKNOWLEDGE** THAT I UNDERSTAND AND AGREE WITH THE POLICIES AND PROCEDURES OUTLINED. I ACKNOWLEDGE AND CERTIFY THAT ALL THE INFORMATION GIVEN TO THE OFFICE/PROVIDER IN THE INTAKE FORMS ARE A TRUE AND ACCURATE TO THE BEST OF YOUR KNOWLEDGE.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Rep.

\_\_\_\_\_  
Personal Representative Printed

\_\_\_\_\_  
Personal Rep. Signature

\_\_\_\_\_  
Description of personal representative's authority to act for the patient