Westside Wellness Chiropractic Center

Chiropractic Case History/Patient Information

Please fill out the following form in as much detail as possible. Please print.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone: _____ email: _____

Age _____ Date of Birth _____ Social Security No._____

Who can we thank for referring you? _____

Primary Care Physician:_____ Telephone:_____

Would you like us to share your information with your Primary Care Physician? YES NO

Occupation _____ Employer _____

Employer's Address: _____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? YES NO

For what problem? _____

Were the results satisfactory? YES NO N/A

INSURANCE INFORMATION:

Name of Insurance Co.	
Phone for Ins. Co.	
Patient Date of Birth	
Primary policy holder	
Claim/Group#	
Insured SS#/ID#	
Employer	

AUTHORIZATION, ASSIGNMENT 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

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 Privacy Policy that is included in this packet. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature authorizing care:_____ Date:_____

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PRESENTING PROBLEM

Major complaints and symptoms — please be specific in describing what brings you in today:
_____
_____
_____

When did you first notice this problem/pain?_____

How do you believe this problem/pain began? _____
_____

What daily activities have been affected? ___sitting ___standing ___walking
___sleeping ___concentrating ___driving ___exercising ___other:_____

Have you seen anyone else for this problem? YES NO
If yes: Who? _____
How long were you treated?_____

Have you ever had this condition before? NO YES, when?_____

Do you have any allergies? YES NO
If yes, please list _____
_____

Are you presently taking any prescription or over-the-counter medications? YES NO
If yes, please list _____
_____

Are you presently taking any vitamins, herbs or other supplements? YES NO
If yes, please list _____
_____

Please list any other health concerns you wish to discuss _____
_____
_____

FAMILY HISTORY

Do you have a family history of any of the following?

Y – you **F – family**

Y	**F**	High Blood Pressure	**Y**	**F**	Ulcer or Stomach Problems
Y	**F**	Heart Attack	**Y**	**F**	Stroke
Y	**F**	Emphysema	**Y**	**F**	Cancer (type:_____)
Y	**F**	Seizures or Convulsions	**Y**	**F**	Arthritis-Rheumatism
Y	**F**	Kidney Disease	**Y**	**F**	Mental Illness
Y	**F**	Asthma	**Y**	**F**	Thyroid Disease
Y	**F**	Diabetes	**Y**	**F**	Circulation Problems
Y	**F**	Other:_____			

Patient's Signature:_____ Date:_____

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REVIEW OF SYSTEMS

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? N = Now P = Previously

Headaches (_____ Frequency)	**N**	**P**	Loss of Balance	**N**	**P**
Neck Pain	**N**	**P**	Fainting	**N**	**P**
Stiff Neck	**N**	**P**	Loss of Smell	**N**	**P**
Sleeping Problems	**N**	**P**	Loss of Taste	**N**	**P**
Back Pain	**N**	**P**	Unusual Bowel Patterns	**N**	**P**
Nervousness	**N**	**P**	Feet Cold	**N**	**P**
Tension	**N**	**P**	Hands Cold	**N**	**P**
Irritability	**N**	**P**	Arthritis	**N**	**P**
Chest Pains/Tightness	**N**	**P**	Muscle Spasms	**N**	**P**
Dizziness	**N**	**P**	Frequent Colds	**N**	**P**
Shoulder/Neck/Arm Pain	**N**	**P**	Fever	**N**	**P**
Numbness in Fingers	**N**	**P**	Sinus Problems	**N**	**P**
Numbness in Toes	**N**	**P**	Diabetes	**N**	**P**
High Blood Pressure	**N**	**P**	Indigestion Problems	**N**	**P**
Difficulty Urinating	**N**	**P**	Joint Pain/Swelling	**N**	**P**
Weakness in Extremities	**N**	**P**	Menstrual Difficulties	**N**	**P**
Breathing Problems	**N**	**P**	Weight Loss/Gain	**N**	**P**
Fatigue	**N**	**P**	Depression	**N**	**P**
Lights Bother Eyes	**N**	**P**	Loss of Memory	**N**	**P**
Ears Ring	**N**	**P**	Buzzing in Ears	**N**	**P**

Women: Are you pregnant?_____

Patient's Signature:_____ Date:_____

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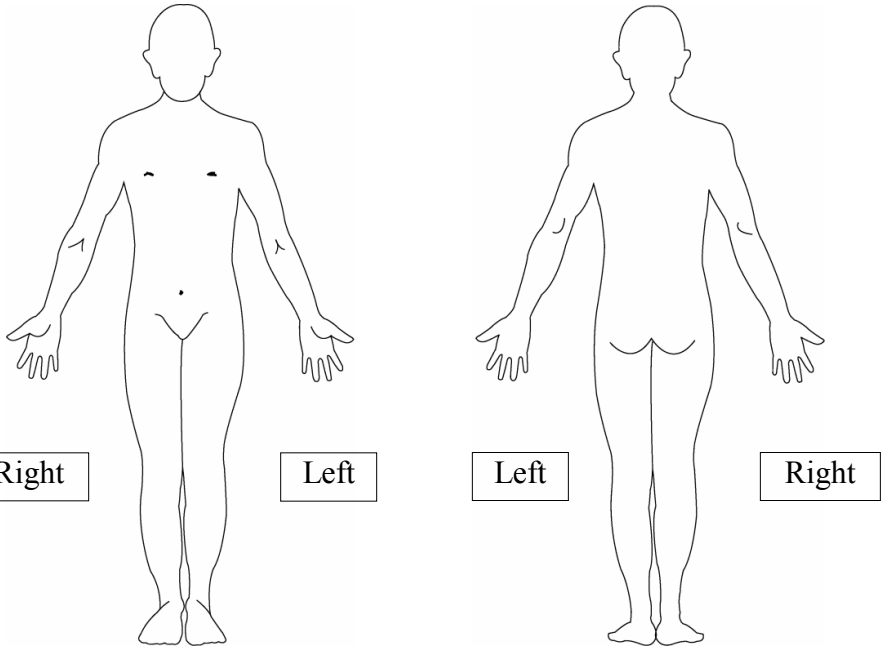
TRIPLE VISUAL ANALOGUE SCALE

Mark the areas on the drawings below where you feel the described sensations.
Use the appropriate symbols. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - -	000	xxx	***	/ / /
- - -	000	xxx	***	/ / /
- - -	000	xxx	***	/ / /

Pain Chart



On the scale from zero to 10, please mark your current level of pain or discomfort.

0_____**10**
no pain **worst pain**

The Pain -

- ☐ Comes and goes
- ☐ Is getting worse
- ☐ Is getting better
- ☐ Is constant
- ☐ Wakes me up at night
- ☐ Is worse in the morning
- ☐ Is worse at the end of the day
- ☐ Is better in the morning
- ☐ Is worse when I _____ _____
- ☐ Is better when I _____ _____

Affects on Lifestyle – (check all that apply)

YOU
- ☐ Trouble falling asleep
- ☐ Interrupted sleep
- ☐ Moody / Irritable
- ☐ Uncomfortable
- ☐ Anxiety / Nervousness
- ☐ Hinders recreational activities

FAMILY
- ☐ Lose patience easily
- ☐ Hinders household activities
- ☐ Poorer attitude at home
- ☐ Less playtime with children
- ☐ Other _____ _____

WORK
- ☐ Less productive
- ☐ Poorer attitude
- ☐ Can't work long hours
- ☐ Hinders decisions
- ☐ Other _____ _____

Signature _____ Date: _____

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Patient Informed Consent for Treatment

I _____ do hereby give my consent to the performance of Chiropractic treatment. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues and physiotherapies and exercises may also be used. I consent to the performance of examinations and testing for proper diagnosis and treatment.

I have disclosed all of my past medical history to Dr. Serinsky so that an appropriate treatment plan can be developed. I am aware of the risks associated with my treatment, the most common of which is soreness in the treated area, and fully and freely accept those risks. I will report any soreness or discomfort that I feel, from the treatment or otherwise, promptly to Dr. Serinsky.

Any questions I have had regarding these treatment procedures, treatment results or treatment alternatives have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

Patient's Signature _____Date_____

Witness's Signature _____Date_____

Westside Wellness Chiropractic Center

Notice of Privacy Policy for Protected Health Information

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY AND LET US KNOW IF YOU HAVE ANY QUESTIONS. A COPY OF THIS FORM WILL BE GIVEN TO YOU UPON YOUR REQUEST.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

Privacy Pledge

We respect our patients' right to privacy and value your trust. We will never provide your contact or health information to any outside organization for marketing or solicitation. In general, we will not disclose your protected health information without your prior written consent. Some exceptions are listed below.

Uses and Disclosures for Which Your Consent is Requested

1) Disclosure to another health care provider for referrals for treatment _____ (initial)
2) Disclosure to third party billing, insurance carrier for payment of services _____ (initial)
3) Disclosure to contact your for appointment reminders _____ (initial)
   May we leave a message on your voicemail? YES/NO

I consent to the above listed disclosures which I have initialed and I understand that I have the right to revoke this consent, in writing, at any time.

Signature_____ **Date**_____

Permitted Uses and Disclosures Without Your Consent

Under federal law, we are permitted to use or disclose your health information without your consent in the following circumstances:

1) If we provide health care services to you based on the orders of another health care provider
2) If we provide health care services to you as an inmate
3) If we provide health care services to you in an emergency
4) If we are required by law to treat you and we are unable to obtain your consent prior to doing so
5) If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care
6) If we have reasonable cause to suspect that a child has been abused
7) If you disclose to us your intent to harm another person

Your Right to Inspect and Copy Your Health Information

You have the right to inspect and/or copy our health information for seven years form the date that the record was created or as long as the information remains in our files. We require that your request to inspect and/or copy your record be made in writing.

Your Right to Amend Your Health Information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require that your request to amend your health information be made in writing and that you give us a reason to support the change that you are requesting us to make.

Your Right to Receive an accounting of the Disclosures We Have Made of Your Record

You have a right to request that we give you an accounting of the disclosures we have made of your record for the last seven years before the date of your request.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your Right to Complain

You may complain to us or to the Secretary of Health and Human Services is you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take action against you if you do so.

Westside Wellness Chiropractic Center

Emergency Contact

We request that you provide us with the name and contact information for a person whom you would like to designate as an emergency contact. By providing the name and contact information for that person, you are authorizing us to speak to the designated person and to use or disclose your health information to that person. You may change your designated emergency contact, by written notification to us, at any time.

Name of Emergency Contact_____

Contact phone number _____

This notice is effective as of February 1, 2005. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have read and understood this notice and that I consent to the privacy policy of Westside Wellness Chiropractic Center.

_____ _____

Patient Name Printed Date

_____

Patient Signature

_____ _____

Witness Signature Date