

CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ Social Security # _____ Driver Lic. # _____
Age _____ Birthdate _____ Sex _____ Status M S W D No. of Children _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Phone _____
Spouse's Name _____ Occupation _____ Employer _____
Person Responsible for this account _____ Referred by _____

What is your major complaint?

Other complaints _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? YES NO Constant Comes and goes
Is this condition interfering with your: Work Sleep Daily routine Other _____
How long has it been since you really felt good? _____
List surgical operations: _____

Are you taking any medications? _____ What kind? _____
Any non-prescription drugs? _____ What kind? _____

OTHER DOCTORS SEEN FOR THIS CONDITION:

MD DC DO DDS

Doctor's

Name _____ Diagnosis _____
X-rays _____ Urinalysis _____ Blood tests _____ Other _____
Treatment: Medication _____ Physiotherapy _____
Results _____ Length of time under care _____
Were you off work? _____ If so, how long _____ Have you returned to you same job? _____ If not, why _____

INSURANCE INFORMATION:

Are you covered by Medicare? YES NO Medicare # _____ State Insurance Aid? YES NO
Do you have any group, union or personal health insurance?
Name of Insurance Company _____ Claim # _____ Group # _____ Agent _____
Address _____ Phone _____
Additional Insurance Company _____ Claim # _____ Group # _____ Agent _____
Address _____ Phone _____
Is your condition due to an accident? YES NO Illness Other _____

Did your accident occur while at work? YES NO Were you involved in an automobile accident? YES NO
Date _____ Time _____ Injury reported to employer _____ Name of supervisor _____
Description of accident _____

Were you injured? _____ How? _____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
Patient taken to _____ Hospital for _____
Confined to hospital for _____ days _____ hours. Name of hospital doctor _____
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
Do you have an attorney? YES NO Name and Address _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediatly due and payable.

Patient's Signature

Date

G101a

IMPORTANT: Please check (X) all present symptoms.

HEAD:

Headache

- sinus (allergy)
- entire head
- back of head
- forehead
- temples
- migraine
- Head feels heavy
- Loss of memory
- Light-Headedness
- Fainting
- Light bother eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK:

- Pain in neck
- Neck pain with movement
 - forward
 - backward
 - turn to left
 - turn to right
 - bend to left
 - bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

ARMS AND HANDS:

- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins and needles in arms
- Sensation of pins and needles in fingers
- Numbness in arms (R-L)
- Fingers go to sleep
- Hands cold
- Swollen joints in fingers
- Sore joints in fingers
- Arthritis in fingers
- Loss of grip strength

SHOULDERS:

- Pain in shoulder joint (R-L)
- Pain across shoulders
- Bursitis (R-L)
- Arthritis (R-L)
- Can't raise arm
 - above shoulder level
 - over head
- Tension in shoulders
- Pinched nerve in shoulder (R- L)
- Muscle spasms in shoulders

MID BACK:

- Mid-back pain
- Location _____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney area

CHEST:

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Low back pain
- Upper lumbar
- Lower lumbar
- Sacroiliac
- Low back pain is worse when:
 - Working
 - Lifting
 - Stooping
 - Standing
 - Sitting
 - Bending
 - Coughing
 - Lying down (sleeping)
- Walking
- Pain relieved when _____
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIP, LEGS, AND FEET:

- Pain in buttocks
- Pain in hip joint
- Pain down leg
- Pain down both legs
- Knee pain
 - inside
 - outside
- Leg cramps
- Cramps in feet
- Pins and needles in legs
- Numbness of leg
- Numbness of toes
- Feet feel cold
- Swollen ankles
- Swollen feet

WOMEN ONLY:

- Menstrual pain _____(where)
- Cramping
- Irregularity
- Cycle _____ days
- Birth control _____ (type)
- Hysterectomy
- Genital cancer _____
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you are pregnant?

MEN ONLY:

- Urinary frequency _____
- Difficulty in starting _____
- Night urination
- Prostate pain/swelling

GENERAL

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep _____hrs/night
- Loss of sleep _____hrs/night
- Loss of weight _____ lbs
- Gain weight _____ lbs
- Coffee _____cups/day
- Tea _____cups/day
- Cigarettes _____pack/day
- Other _____
- Diabetes
- Hypoglycemia

REMARKS:

Patient's Signature _____ Date _____

Innate Chiropractic
916A San Pablo Ave.
Albany, CA 94706
(510) 528-5216 Ph (510) 528-5256 Fax

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient for whom I am legally responsible) by the doctors of chiropractic named above, or any others working at this office.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise such judgment during the course of the procedure, which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment of my present condition and for my future condition(s) for which I seek treatment.

Signature _____

Date _____

PRIVACY POLICY

I have also read and received a copy of the HIPPA Privacy Statement provided by this office.

Initial _____

PAYMENT AND INSURANCE INFORMATION

If you are here because you have been involved in an automobile accident, a personal injury accident, or an on-the-job injury, please fill out the accident form.

PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE!

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that **Innate Chiropractic** will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also understand that I may be entitled to a discount if treatment is paid in full at the time of visit. I also give **Innate Chiropractic** power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Signature _____

Date _____

Relationship to patient: SELF SPOUSE PARENT GUARDIAN

Insurance Company Name _____

Name of Insured _____

OVER PLEASE

Innate Chiropractic
916A San Pablo Ave.
Albany, CA 94706
(510) 528-5216 Ph (510) 528-5256 Fax

Cancellation Notice: Please give us 24 hours notice of any cancellations, as your space is being held for you. The charge of a missed appointment is \$50. Your insurance company will not pay for missed appointments.

Initials _____

Children/Family: Once you understand that the nervous system controls and coordinates all functions of the body and subluxations interfere with the nerve flow, we expect that you would want everyone in your family checked. We have a cost-effective family program for you. We extend an opportunity for you to have your family checked at a discounted rate within 1 month of starting care.

Initials _____

Interruption of Care: In the unlikely event it is necessary to discontinue your care for any reason let us know. We will make every attempt to accommodate you and make affordable arrangements if needed.

Initials _____

Referrals: The success of our office and the health of your loved ones greatly depend on your referrals. If there is someone you know that you would like to have invited to our office, please let us know.

Initials _____