

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: _____

Person to contact in case of emergency: _____ Phone _____

How were you referred to our office? _____

Family Medical Doctor: _____

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

HISTORY OF PRESENT 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? Yes No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

- | | | |
|--|---|--|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Ruptures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers |

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? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting _____ sitting _____ bending _____ working at a computer _____

FAMILY HISTORY:

Parents:

Father: living ___ deceased ___ Current age if still living: _____ Cause of death and age at death if deceased: _____ (check one)

Mother: living ___ deceased ___ Current age if still living: _____ Cause of death and age at death if deceased: _____ (check one)

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis _____

Cancer _____

Mental Illness _____

Diabetes _____

Asthma _____

Heart Disease _____

Stroke _____

Kidney Disease _____

Lung Disease _____

Arthritis _____

Liver Disease _____

Other _____

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. If there is anyone you do not want to receive your medical records, please inform our office.

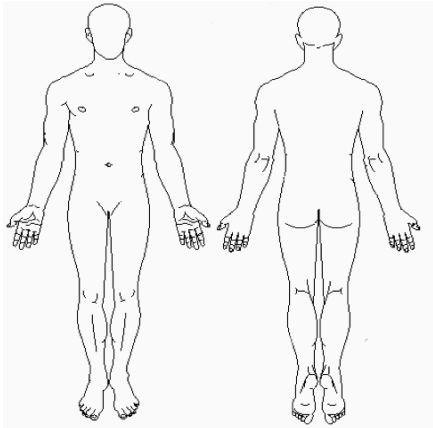
Patient's Signature: _____

Date: _____

Guardian's Signature Authorizing Care: _____

Date: _____

SUMMARY



Where is your pain?

Please use the appropriate symbols to mark the areas of the body where you feel the following sensations:

Ache= AA Pins & Needles=*** Fatigue= ZZZ Tension=XXX Stabbing=//
Restriction=RR Burning=^^^ Numbness=++
Other=???

Please circle the appropriate number to indicate your level of pain:

(No pain sensation) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain sensation)

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ Few Hours ___ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
Yes ___ No _____. If yes, describe: _____
Are there other unrelated health problems? Yes ___ No _____. If yes, describe _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No _____. If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____

8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain _____
11. Remarks: _____

Name: _____ Date _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Hewett-McNeil Family Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

PREGNANCY WAIVER

I hereby acknowledge that Dr. Hewett-McNeil of Hewett-McNeil Family Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Printed Name of Patient

Signature of Patient/Authorized Representative of Patient

Witness

Date

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Patient Signature: _____ Date: _____

AUTHORIZATION TO USE MY NAME OR PICTURE

I give you permission to use my name and picture in your patient newsletter, website, publication and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Patient Signature: _____ Date: _____

Name of Patient _____ Date _____

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.
2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.
5. Unless indicated by the doctor, you may return to work/school after your appointment.
6. If a sudden movement causes sharp or severe pain, or if you experience swelling, contact the clinic at _____. After hours, contact _____ at _____.

I have read and understand the instructions given for my follow-up care.

Patient's Signature

Date

Authorization for the Release of Medical Records

Patient Name: _____ Date of Birth: _____
(also list maiden name/other names used)

I hereby request and authorize:

Hewett-McNeil Family Chiropractic
Dr. Malissia Hewett-McNeil, D.C.
8303B Office Park Dr- Douglasville, GA 30134- 678-715-3131

_____ **To Disclose information to:** _____ **To Receive Information from:**

Provider: _____

Address: _____

City/State/Zip _____

Information to be disclosed include copies of:

_____ Entire Record	_____ X-ray Reports
_____ Progress Notes	_____ X-ray Films
_____ Physical Exam forms	_____ Other, specify:
_____ Daily chart notes	_____

Purpose for disclosure:

_____ Treatment, Payment OR _____ Other (Specify) _____

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

_____ Date: _____
Signature of Patient

OR
_____ Date: _____
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date