Silver Chiropractic & Wellness

CONFIDENTIAL PATIENT CASE HISTORY

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. *Please sign each page.*

PATIENT INFORMATION

(Underline) DR/ MR/ MRS/ MISS/ MS: TODAYS DATE:____/_____/_______

FIRST NAME:____________________ LAST NAME:____________________ MIDDLE INIT:_______

ADDRESS:________________________________CITY/STATE:_______________ZIP:__________

HOME PHONE:______________AGE:____ BIRTH DATE:___/___/___ SOC. SEC# :____/____/_____

CELL PHONE _____________________ EMAIL ____

MARITAL STATUS: MARRIED/ SINGLE/ DIVORCE/ WIDOW (*PLEASE CIRCLE*) # OF CHILDREN: _____

OCCUPATION: ____________________EMPLOYER: ___________________WORK#: ____________

SPOUSE'S NAME: ________________SPOUSE'S EMPLOYER: ___________WORK#:___________

FAMILY PHYSICIAN: _________________ ADDRESS: ___________________ PHONE#: __________

FAMILY DENTIST: __________________ADDRESS: ___________________ PHONE: ____________

HEALTH INFORMATION*

WHAT ARE THE CHIEF COMPLAINTS FOR, WHICH YOU ARE SEEKING TREATMENT?
(*IN ORDER OF IMPORTANCE WITH 1 BEING MOST IMPORTANT.*)

1.__________________ 4.____________________ 7.________________ 10.________________

2.__________________ 5.____________________ 8.________________ 11.________________

3.__________________ 6.____________________ 9.________________ 12.________________

How long have you had this condition(s)? ____________________

Have you had this condition in the past? ______________

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?____________________________________
Other Doctors who treated this condition____
Date of last physical examination____
List surgical operation and years____

SIGNATURE: X_________________________________**Date:**___________________________

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List any medications that have caused an allergic reaction________________________________

List any currently being taken: 1. ____________ 2. ____________ 3. ____________

4. ____________ 5. ____________ 6. ____________

Are you wearing: [ ]Sole lifts [ ]Heel lifts [ ]Inner soles [ ]Arch supports [ ]Pacemaker

Have you ever been in an auto accident? [ ]YES [ ] NO When?____________

Describe: ________________________________

Have you had any other personal injury or accident? [ ] YES [ ] NO When?____________

Describe: ________________________________

Are you pregnant? [ ] YES [ ] NO [ ] MAYBE

List treatments you have had for this problem and all health professionals that you are currently seeing:

PHYSICIANS	SPECIALTY	TREATMENT & APPROX. DATES
1.		
2.		
3.		
4.		
5.		
6.		

PATIENT SIGNATURE: X________________________ **DATE:**__________

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***PLEASE CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOUR MEDICAL HISTORY**

ALLERGIES:
[ ] Hay Fever
[ ] Food Allergies:___________________
[ ] Allergic to:______________________

ARTHRITIS:
[ ] Gout
[ ] Osteoarthritis: Specify Joint:________
[ ] Rheumatoid Disease
[ ] Other:__________________________

ENDOCRINE DISORDERS:
[ ] Diabetes
[ ] Hypoglycemia
[ ] Parathyroid Disease
[ ] Thyroid Disease
[ ] Other:__________________________

EYE DISORDERS:
[ ] Glaucoma
[ ] Ocular Herpes
[ ] Other:__________________________

HIV DISORDERS:
[ ] Tested HIV Positive
[ ] Aids
[ ] Other:__________________________

KIDNEY/URINARY DISORDERS:
[ ] Bladder Infections
[ ] Blood in urine
[ ] Kidney Disease
[ ] Sugar in Urine
[ ] Other:__________________________

MUSCLE DISORDERS:
[ ] Muscular Dystrophy
[ ] Muscle Shaking (tremors)
[ ] Muscle Spasms or Cramps
[ ] Other:__________________________

NERVE DISORDERS:
[ ] Cerebral Palsy
[ ] Epilepsy
[ ] Neuralgia
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Stroke
[ ] Other:__________________________

ARTIFICIAL IMPLANTS:
[ ] Heart pace maker
[ ] Heart Valve
[ ] Joint replacement: specify joint & side:______
[ ] Other:________________________________

BLOOD DISORDERS:
[ ] Anemia
[ ] Bleeding Easily
[ ] Hemophilia
[ ] Leukemia
[ ] Sickle Cell Anemia
[ ] Other:__________________________

HEART/CIRCULATORY DISORDERS:
[ ] Arteriosclerosis
[ ] Congenital Heart Disorders (at birth)
[ ] Coronary Artery Disease
[ ] Heart Murmur
[ ] Heart Palpitations
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Poor Circulation
[ ] Rheumatic Fever
[ ] Other:________________________________

LIVER DISEASE:
[ ] Cirrhosis of the Liver
[ ] Hepatitis A (infectious)
[ ] Hepatitis B (serum)
[ ] Other:________________________________

LUNG/RESPIRATORY DISORDERS:
[ ] Asthma
[ ] Chronic Colds
[ ] Emphysema
[ ] Frequent Cough
[ ] Lung Cancer
[ ] Shortness of Breath
[ ] Tuberculosis
[ ] Other:________________________________

STOMACH/INTESTINAL DISORDER:
[ ] Bloating
[ ] Colitis
[ ] Constipation
[ ] Frequent Diarrhea
[ ] Frequent Gas
[ ] Gallbladder Problems
[ ] Heartburn
[ ] Ulcers [ ] Other:__________________

SIGNATURE: X ____________________________ **DATE:**__________________

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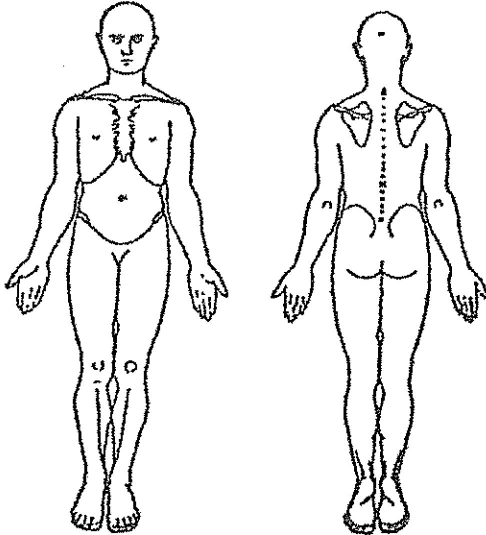
Please mark your areas of pain on the figures below.



Have you ever suffered from:

[ ] Dizziness____________________
[ ] Backaches____________________
[ ] Heart Trouble____________________
[ ] Diabetes____________________
[ ] Arthritis____________________
[ ] Headaches____________________
[ ] Asthma____________________
[ ] Neuritis____________________
[ ] Digestive Disorders____________________
[ ] Nervousness____________________
[ ] Sinus Trouble____________________
[ ] Neck Pain____________________
[ ] Other:____________________

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FAMILY HEALTH INFORMATION

(Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health picture.)

Father:____

____

Mother:____

____

Sister:____

____

Brother:____

____

Other:____

____

PLEASE THINK...Is there anything else the doctor should know about you? ____________________

____

____

SIGNATURE: X______________________________ **DATE:** ________________

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INSURANCE INFORMATION:**

Health Insurance:____
Subscriber
Name / Number:____________________ Group #________________________

Secondary Health Insurance: ______________________________________
Subscriber
Name / Number:____________________ Group#________________________

Automobile
Insurance:____
Date & Time of Accident:________________Name of the insured: ____________
Policy #:________________________ Claim #:________________________
Name of Adjuster:___________________

If you do not have your own insurance, do you live with anybody who does?____________
Name of the Insured:______________________ How are you related?__________
Policy #:____________________________ Claim #:____________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Silver Chiropractic & Wellness will* prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to *Silver Chiropractic & Wellness will* be credited to my account on receipt. However, 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 professional services rendered to me will be immediately due and payable.

PATIENT SIGNATURE: X_________________________

GUARDIAN or SPOUSE'S SIGNATURE: X_________________________

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AUTHORIZATION for MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray and physical findings diagnosis and prognosis. You are authorized to provide this information.

X_________________________________ ____________________

SIGNATURE **DATE**

Silver Chiropractic & Wellness

ASSIGNMENT OF BENEFITS

The undersigned patient hereby assigns the benefits of insurance with

____ to:
(Insurance Company)

Silver Chiropractic & Wellness and its physician *Dr. Shane H. Silver* for services rendered to the undersigned patient and covered under __________________policy with
(Insured's Name)

________________________________ .
(Insurance Company Name)

The undersigned further agrees to pay any applicable deductible or co-payment not covered by insurance.

PATIENT SIGNATURE: X_______________________DATE:__________

The undersigned hereby accepts assignment of insurance benefits for services rendered to

________________________________ and to be paid directly to me under
(Patient's Name)

________________________________ Insurance coverage and benefits.
(Insured's Name)

____
(Doctor's Signature)

____
(Date)

____
(Witness)

Silver Chiropractic & Wellness

Shane H. Silver, D.C.

CONSENT FOR TREATMENT

I hereby authorize your practice and whomever the doctor may designate as his assistant to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

DATE: ____________________

SIGNATURE: X____

Medical Information Release Form

(HIPAA Release Form)

Name: ______________________________ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse______________________________

[ ] Child(ren)____________________________

[ ] Other______________________________

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ______________________________

The best time to reach me is (*day*)______________ between (*time*)________

Signed: ______________________________ Date: ____/____/____

Witness:______________________________ Date: ____/____/____