SCHUCK FAMILY CHIROPRACTIC

76 East 15th Street
Edmond, Oklahoma 73013

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____________

PATIENT INFORMATION

Name: (Last, First MI)____ Preferred Name: _________________

Address: _______________________________________ City: ______________________ State: ______ Zip: __________

Phone: ________________ Work: ________________ Email: ____ Gender: M / F

Marital Status: Married / Other / Single Social Security #:___________________________________

Date of Birth: ___________________________________ Employed Employer: _______________________

Student Status: Full Student / Part Student / Non-Student

*Referred By: ____________________________________

Ethnicity: Hispanic or Latino / Other Preferred Language: ______________________________

Race: Asian / African Am. / Am. Indian or Alaskan Native /Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ______________________________________ Home: _________________ Mobile: _________________

Relationship: Child / Parent / Spouse / Other: ___________

FINANCIAL INFORMATION

Primary Care Physician: ___________________________ Doctor's Phone: __________________________________

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (please explain):________

PRIMARY INSURANCE

Name: ____ Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: ______________________ Gender: M / F Address: ____ City:

___________________ State: _____ Zip: ________ Phone: ___________________ Date of Birth: __________

SECONDARY INSURANCE

Name: ____ Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: ______________________ Gender: M / F Address: ____ City:

___________________ State: _____ Zip: ________ Phone: ___________________ Date of Birth: __________

Who is responsible for payment? Self / Other - (Relationship) ___________________________

Other than Self:

Full Name: ______________________________________ Phone: ___________________

Address: ____ City: ____________________ State: ______ Zip: __________

Patient File # _______

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ____

Began When? ____/_____/______ Describe how this began:____

____

____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:

______________________________ How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes

(Describe)_______________________________________

Head - Base of Skull / Forehead / Sides-Temple R / L / Both Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both Other Area: ____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other:

____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other:

____

Which daily activities are being affected by this condition? (Describe) ____

For this CURRENT condition, have you:

Received any other treatment? None / DC / MD / PT / Massage / ER / Other: ______________ Where:__________________

Had any previous Surgery or Interventions in this area? (Describe)____

Taken any Medications? OTC / Prescriptions ____

Had any diagnostic testing? X-rays / MRI / CT / Other: _______________ When and Where? ___________________________

Describe any Secondary Complaints: ____

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications:

Allergies to Medications: NONE (List)

____

____

Current Medications: NONE

(Already have a list? We can make a copy.)______________________

____

____

____

____

Past Health History: (Please list any past...)

Surgeries – Date, Type, and Reason: NONE

____

____

____

____

Major Injuries/Traumas: NONE ____________________

____

____ Major Hospitalizations: NONE ______________________

____

____ Family Health History: (Please mark N/A if not relevant.) List relevant major health problems of immediate relatives:

____

____

____ Deaths in immediate family: (Cause and at what Age?)

____

____

____

Patient File # _______

Social and Occupational History:

Level of Education Completed:

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins) ____

____

Habits:

Cigarettes – (#/day) ________________________________ Alcohol – (amount/day)________________________________

Coffee/Tea – (cups/day)_____________________________ Rec. Drugs (List)__________________________________

General: (constitutional)

__Recent Weight Change

__Fever

__Fatigue

__None in this Category

Musculoskeletal:

__Low Back Pain

__Mid Back Pain

__Neck Pain

__Arm Problems ______________ Leg Problems ______________ Painful Joints

__Stiff/Swollen Joints

__Sore/Weak Muscles or Joints Muscle __Spasms/Cramps

__Broken Bones_______________

Other: ____________________

None in this Category

Neurological:

__Numbness or tingling sensations Loss of Feeling

__Dizziness or light headed

__Frequent or Recurrent Headaches

__Convulsions or seizures

__Tremors

__Stroke

Have you ever had a head injury? Ever been in an auto accident?

Other: ____________________

__None in this Category

Mind/Stress:

__Nervousness

__Depression

__Sleep Problems

__Memory Loss or Confusion

Other: ____________________

__None in this Category

Genitourinary:

__Sexual Difficulty

__Kidney Stones

__Burning/Painful Urination

__Change in force/strain w Urination

__Frequent Urination

__Blood in Urine

____Incontinence or Bed Wetting

__None in this Category

Other: ____________________

Gastrointestinal:

__Loss of Appetite

__Blood in Stool

__Change in Bowel Movements

__Painful Bowel Movements

__Nausea or Vomiting

__Abdominal Pain

__Frequent Diarrhea

__Constipation

Other: ____________________

__None in this Category

Cardiovascular & Heart:

__Chest Pains

__Rapid or Heartbeat changes

__Blood Pressure Problems

__Swelling of Hands, Ankles, or Feet

__Heart Problems

Other: ____________________

__None in this Category

Respiratory:

__Difficulty Breathing

__Persistent Cough

__Coughing Blood

__Asthma or Wheezing

__Lung Problems

Other: _______________

__None in this Category

Eyes and Vision:

__Wear contacts/glasses

__Blurred or double vision

__Glaucoma

__Eye disease or injury

Other: ____________________

__None in this Category

Ears, Nose and Throat:

__Bleeding gums / mouth sores

__Bad Breath or bad taste

__Dental Problems

__Swollen throat or voice change

__ Swollen glands in neck

__Ringing in the ears

__Ear - Ache/Ringing/Drainage

__Sinus / Allergy problems

__Nose Bleeds

__Hearing Loss

Other: ____________________

Patient File # _______

Endocrine, Hematologic, and Lymphatic:
__Thyroid problems
__Diabetes
__Excessive Thirst or urination
__Cold Extremities
__Heat or Cold intolerance
__Change in hat or glove size
__Dry skin
__Glandular or hormone problem
__Swollen Glands
__Anemia
__Easily Bruise or Bleed
__Phlebitis
__Transfusion
__Immune system disorder
Other: ____________________
__None in this Category

Skin and Breasts:
__ Rash or Itching
__Change in Skin Color
__Change in hair or nails
__Non-healing sores
__Change of appearance of a mole
__Breast Pain
__Breast Lump
__Breast Discharge
Other: ____________________
__ None in this Category

Women Only:
Are you pregnant?
Yes - Due Date ___/____/____
No - Last Menstrual Period ___/____/____
__Infertility
__Painful or Irregular periods
__Vaginal Discharge
Other: ____________________
__None in this Category

Pregnancies with Outcome & Date:
____
____
____

Comments:
____
__________ ____ I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature ____ Date___________________

Treating Doctor Signature ____ Date___________________

Patient File # _______

ASSIGNMENT OF HEALTH BENEFITS

No.________________

The parties appearing below, on the ___ day of ___, 20__, hereby agree to the following conditions, covenants and terms regarding the assignment of health benefits appearing in Mr./Mrs./ Ms. ____ policy issued by ____________________________________.

I, ________________________ hereafter referred to as "Patient", understand and voluntarily agree to assign all applicable health provisions pertaining to payments or benefits appearing in my insurance policy with ______________ in consideration for treatment rendered by Schuck Family Chiropractic. Hereafter referred to as "Doctor".

That Patient, the policy holder, requests, orders and directs _______________________
To pay Doctor directly to his/her office at 76 E. 15th Street Edmond, OK 73013 the sum due Doctor for treatment rendered.

The Doctor and Patient hereby entered into this assignment of benefits freely and voluntarily and evidenced by the signatures appearing below. That Patient and Doctor warrant that they have read this assignment of benefits and that each understand the legal effect of the same, and agree that each shall be bounded by the covenants, terms and conditions appearing herein.

Patient________________________________ Date ______________

Doctor________________________

Patient File # ______

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our
office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

____ Patient Signature _____________________________ Date

Patient File # _______