Tri-County Spine and Rehabilitation

New Patient Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____SS #_____Home Phone: _____

Address:_____City:_____State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____

Age:_____ Birth Date:_____ Marital Status: Married Single Widowed Divorced

Occupation:_____ Employer:_____

Employer's Address:_____ Work Phone:_____

Spouse:_____Occupation:_____ Employer:_____

How many children?_____ Are you pregnant or is there a chance you are pregnant? □ Yes □ No

May we contact you via email regarding appointment reminders, newsletters, etc? □ Yes □ No

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Have you had previous chiropractic care? □ Yes □ No Dr.'s Name_____

Date last seen_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update 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:_____

_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having any of the following? (Place a check by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__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?_____

FAMILY HISTORY:

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

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Other _____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____

Mental Illness____
Heart Disease ____
Lung Disease____

Please check any and all insurance coverage that may be applicable in this case**:**

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident
□ Medical/Health Savings Account & Flex Plans □ Self Pay □ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize and direct payment of insurance benefits directly to this office and/or provider. I authorize the doctor(s) to release all information necessary to communicate with other physicians and healthcare providers and/or payors to secure the payment of benefits or amounts owed. I understand that I am responsible for all costs of treatment, regardless of insurance or alternative coverage. I direct any payment due for services to be rendered to the provider at Tri-County Spine and Rehab any sum I owe by myself, my attorney, out of the proceeds of any settlement of my case, and/or by the insurance company with whom I currently hold a policy. I further understand that this office reserves the right to charge interest at 1½% per month on outstanding balances over 120 days. I give my permission to be examined and treated, realizing that any medical treatment may result in injury and/or death, and agree that if it becomes necessary to turn my account over for collection, I will be responsible for any collection/attorney fees incurred plus all applicable interest.

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:_____

Office Use Only
□ 1
□ 4-5
□ >5

Name:_____Date:_____

Pain Drawing

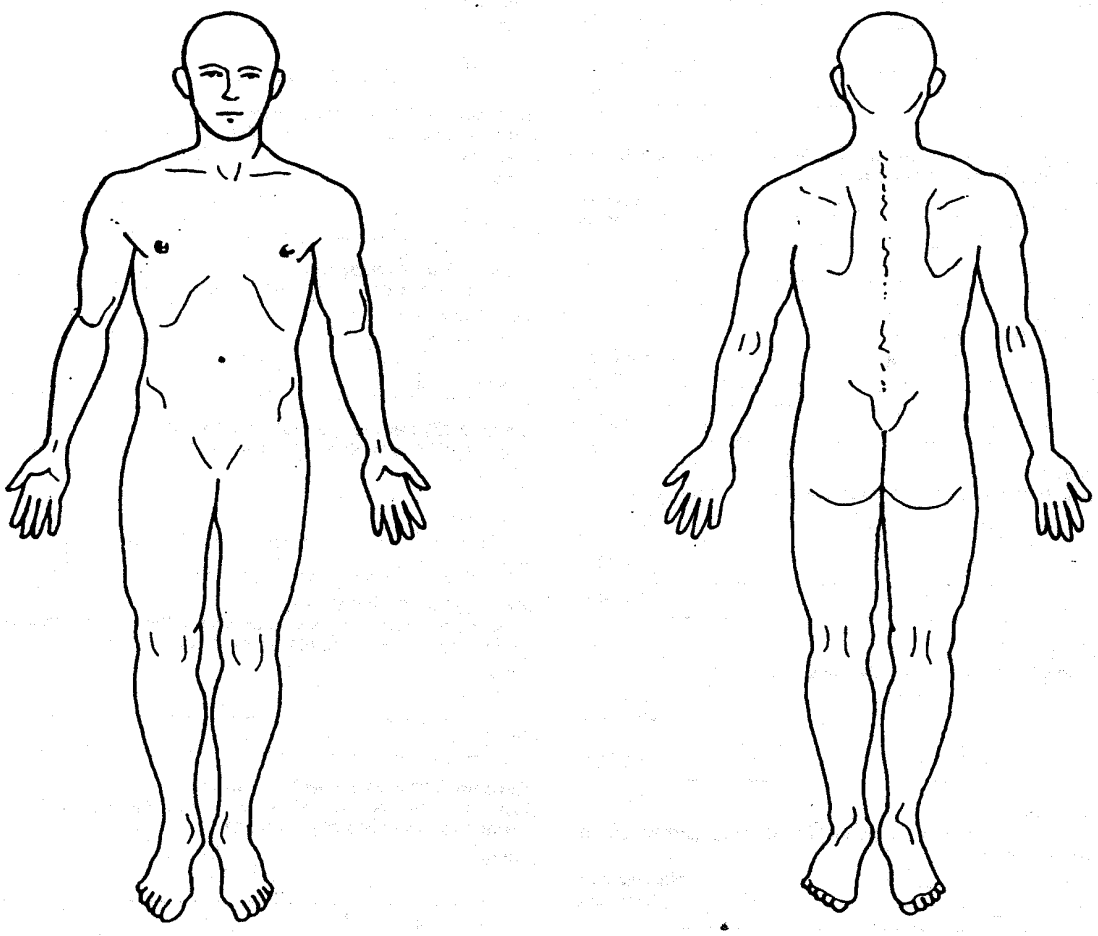
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o

Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



Please place an "X" on the line to indicate your level of pain.

No Pain Extreme Pain