

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (First MI Last) _____ **Preferred Name:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home: _____ **Mobile:** _____ **Work:** _____
Email: _____ **Gender:** M / F **Marital Status:** Single / Married / Other
Date of Birth: _____
Student Status: Full-time / Part-time **Employed:** Y / N **Employer:** _____
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____
Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline
***Referred By:** (Name): _____ Family / Friend / Co-Worker / Doctor / Promotion / Other Source

EMERGENCY CONTACT INFORMATION

Name: (First MI Last) _____ **Primary Care Physician:** _____
Home: _____ **Mobile:** _____ **Doctor's Phone:** _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

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

PRIMARY INSURANCE

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

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:** _____

RESPONSIBLE PARTY

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

Other than Self:

Name: (First MI Last) _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Email:** _____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

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

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers 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 diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

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

Medications and Supplements:

Allergies to Medications: *NONE*

| Name | Reaction |
|------|----------|
| | |
| | |
| | |

Current Medications & Supplements: *NONE*

| Name | Dosage | Frequency | Method |
|------|--------|-----------|--------|
| | | | |
| | | | |
| | | | |
| | | | |

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

Number of Falls in the last 24 months: _____ **Injuries?** Y or N

Surgeries: *NONE*

| Date | Area of the Body | Reason |
|------|------------------|--------|
| | | |
| | | |
| | | |

Major Injuries / Traumas / Hospitalizations: *NONE*

| Date | Describe |
|------|----------|
| | |
| | |
| | |

Family Health History:

N/A

List relevant major health problems of First degree relatives:

| Problem | Parent (M or F) | Sibling (B or S) | Child (S or D) |
|---------|-----------------|------------------|----------------|
| | | | |
| | | | |
| | | | |
| | | | |

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

| Habit | Type | Amount | Year Started |
|------------|------|--------|--------------|
| Smoking | | | |
| Tobacco | | | |
| Alcohol | | | |
| Caffeine | | | |
| Rec. Drugs | | | |

Education: High School / College Grad. / Post Grad. / Other:

| Lifestyle | Describe |
|------------|----------|
| Hobbies | |
| Recreation | |
| Exercise | |
| Diet | |
| Work | |
| Other | |

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

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 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
- Force/strain w/ Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Other: _____
- None in this Category

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
- Burning/Painful in the ears
- Ear - Ache/Ringing/Drainage
- Sinus / Allergy problems
- Nose Bleeds
- Hearing Loss
- Other: _____
- None in this Category

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

⁹³Pregnancies:

| Date | Outcome |
|------|---------|
| | |
| | |
| | |
| | |

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.

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Signature of Patient/Parent or Guardian: _____ Date: _____

Signature of Treating Doctor: _____ Date: _____

Stone Creek Chiropractic, P.C.
5126 N 156th St.
Omaha, NE 68116

w: (402) 614-7717
f: (402) 614-7722
drnielsen@stonecreekchiropractic.com
www.stonecreekchiropractic.com

Patient: _____ DOB: _____ Date: _____

CONSENT FOR CHIROPRACTIC SERVICES

By reading below I have been made aware that:

1. The process of delivering a “Chiropractic Adjustment” (manipulation) may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of Acu Tacs, electricity, traction, motion, bracing, laser, nutritional advice, heat, or cold;
3. On occasion, some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. The chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case.

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Signature of Patient/Parent or Guardian: _____

Signature of Witness: _____

Patient No: _____

Dr. Initials: JN

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TERMS OF ACCEPTANCE

Patient: _____ DOB: _____ Date: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the terms of acceptance as a patient. If you refuse to sign this terms of acceptance form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above named patient.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that a) there is no chance you are pregnant at this time, b) you have no known limitations that would be a contraindication for an x-ray evaluation, and c) you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you acknowledge that a) you are fully responsible for all services rendered, b) you understand that your health and accident insurance policies are an arrangement between you and your carrier and that you may be required to pay some or all of the fees charged to your account, c) you hereby assign benefits to be paid directly to this office/provider by your third-party payer (e.g. insurance company, attorneys, etc.), and d) you acknowledge that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File." Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters in the following manner: phone (work, home or mobile), e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone (work, home or mobile). Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliged to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below, you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form and certify that all the information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Signature of Patient/Parent or Guardian: _____

Patient No: _____

Dr. Initials: JN

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