INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____________

PATIENT INFORMATION

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

Address: ______________________________________ **City:** ______________________ **State:** _______ **Zip:** ___________

Home: ________________ **Mobile:** _________________ **Mobile Carrier:** ___________________ **Work:** _________________

Email: ____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #:_________________________________ **Date of Birth:** __________________________________

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

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 / 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:** ____________________________________

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

Patient No: ___________

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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	

Patient No: ___________

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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
- ☐ 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
- ☐ 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
- ☐ Ringing 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*

Pregnancies:

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.

Patient or Guardian Signature ______________________________ Date________________

Treating Doctor Signature ______________________________ Date________________

Patient No: ___________

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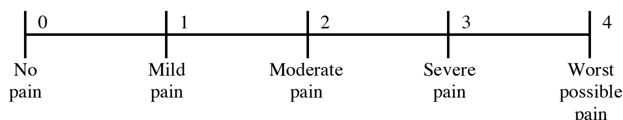
Functional Rating Index

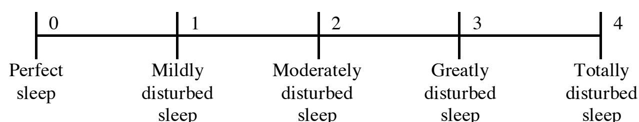
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

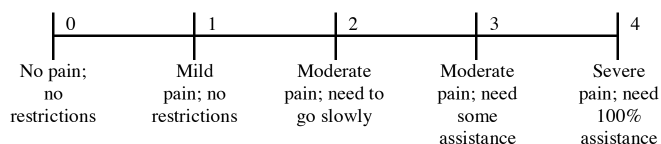
1. Pain Intensity



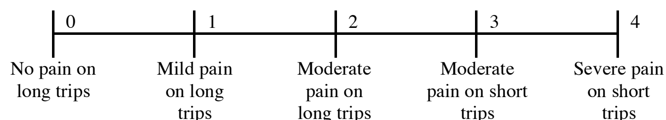
2. Sleeping



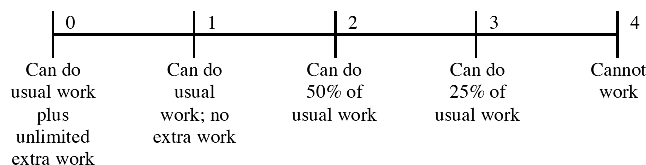
3. Personal Care (washing, dressing, etc.)



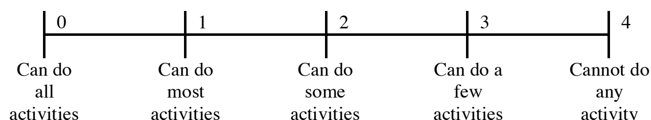
4. Travelling (driving, etc.)



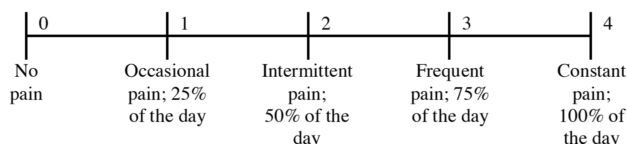
5. Work



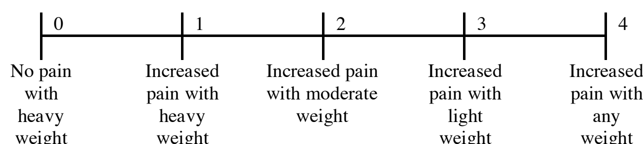
6. Recreation



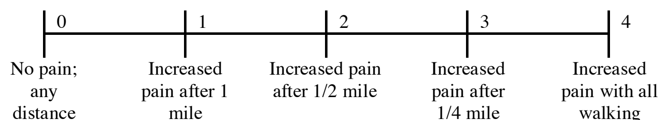
7. Frequency of Pain



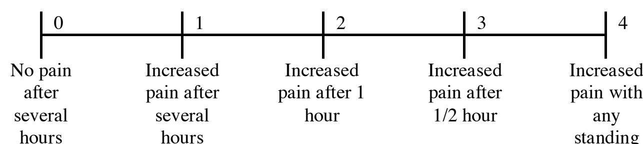
8. Lifting



9. Walking



10. Standing



____

Patient's Signature

____

Date

For Office Use Only:

Clinical Diagnosis Codes:

Practitioner ID#: ____________________________________

Patient ID#: ____________________________________

Total Score __________________ / 40

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HIPPA Notice of Privacy Practices

Porter Chiropractic and Acupuncture, LLC

This notice describes how medical information about you may be used & disclosed, and how you can get access to this information. PLEASE REVIEW CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer, Russ Porter at (816) 524-5838

Patient Name (Please Print): ____

I, the patient, understand that as a part of my healthcare, Porter Chiropractic and Acupuncture, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care & treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and,
- A tool for routine healthcare operations such as assessing quality & reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that *Porter Chiropractic and Acupuncture, LLC* is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.520 of the Code of Federal Regulations.

I further understand that *Porter Chiropractic and Acupuncture, LLC* reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should *Porter Chiropractic and Acupuncture, LLC* change their notices, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or healthcare operations, it my become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted purposes, including disclosures via fax.

This letter states the information you provide will not be released to anyone without your consent. This office is compliant with Federal Law.

Your signature indicates that you're aware of your rights and that our office maintains your information.

Patient/Guardian Signature: ____________________________________ Date: _______________

Insurance Information & Consent Of Professional Services & Release Of Information

I hereby authorize the doctor and whomever he or she may designate as his or her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractor care or any clinic services that he/she deems necessary in any case. Also, even though chiropractic is considered to be a safe form of healing there is a remote chance for adverse effects to occur either temporarily or permanently. If you have any concerns about this statement or the possibilities of adverse effects, please ask Dr. Russ Porter. I also give my consent to Porter Chiropractic and Acupuncture, LLC to consult other doctors and/or radiologist to assist in diagnosis and treatment. I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract with the clinic or to the patient or to the insurance companies, workers compensation carriers, welfare funds, or the patient's employer. I have read and understand this clause and this authorization applies to all services rendered by Porter Chiropractic and Acupuncture, LLC until my legal representatives or I revoke it, in writing.

Patient/Guardian Signature: ____________________________________ Date: ________________