

Case History

Patient Name: _____

First

Middle

Last

GENERAL INFORMATION

Today's Date: ____/____/____ Home Phone: (____) _____ Cell Phone: (____) _____

Cell Carrier: AT&T / Sprint / _____ e-mail address or alt phone : _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: ____/____/____ Sex: Male - Female Social Security #: ____/____/____ Drivers Lic #: _____

Marital Status: S / M / D / W Which hand do you write with?: R / L / Both Ht: _____ Wt: _____ lbs. Spouse's Name: _____

Your Occupation: (Job Title) _____ Length of Employment: _____ yrs. _____ mo.

Employer's Name: _____ Work Phone: (____) _____

Nature of Business/Employment: _____

Employers Address: _____ City: _____ Zip: _____

Spouse's Occupation: _____ Number of Children: _____ Ages: _____

Name of Emergency Contact: _____ Phone: (____) _____

Who or How Were You Referred to This Office: _____ Who is responsible for your account? _____

Reason / Purpose of This Appointment: _____

Have you ever received Chiropractic Care? No Yes, was seen by Dr. _____

Have you ever had any therapy/massage before? No Yes If yes, what type did you receive? _____

SYMPTOMS & ILL HEALTH (Present State of Ill Health)

Present Complaint/s: _____

Major complaint: _____

Pain or problem started on: _____ Any previous episodes of same condition? _____

Pains are: Sharp Achy Dull Throbbing Constant Intermittent Other: _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is your condition worse during certain times of the day? _____

Is this condition interfering with Work? Sleep? Routine? Family? Other: _____

Is your condition getting progressively worse? Yes No Other: _____

Any other complaints or symptoms (please check all that apply):

Neck pain Stiff neck Pins/needles in legs Pins/needles in arms Fainting Cold hands Cold feet

Back pain Numbness in fingers Numbness in toes Difficulty chewing Insomnia Headaches

Double vision Constipation Reduced hearing Loss of taste Loss of smell Flushed face

Eyes sensitive to light Nervousness Tension Irritability Lightheaded Ringing in ears

Buzzing in ears Diarrhea Upset stomach Extreme fatigue Reduced appetite Weight gain

Weight loss Abdominal pain Dark black stool Bright red stool Coughing Restlessness Depression

Dizziness Loss of balance Excessive sweat Cold sweats Dry mouth Bloating Blurred vision

Nausea Poor memory Vomiting Difficulty swallowing Difficulty breathing Shortness of breath
 Blood in urine Pain on urination Sinus problems Menstrual irregularity Vaginal pain/infections
 Breast/Chest pain or lumps Prostate/Sexual dysfunction Excessive thirst Cold extremities
 Ankle swelling Asthma Other: _____

Do you have any forms of CANCER at this time? _____

Other Doctors Seen at this time: MD DC DO DDS Names: _____

Diagnosis: _____ Other Tests: X-rays MRI CT Blood Work Urinalysis

Treatment: Medications: _____ Physiotherapy: _____ Other: _____

Results: _____ Length of time under care: _____ Yrs _____ Months - Frequency of Visits: _____

Are you currently taking any medications either prescribed or over the counter: No Yes: _____

Any other comments or things that we should know? _____

PAST MEDICAL HISTORY

Have you ever had? Sugar Diabetes Tuberculosis Heart Disease High Blood Pressure Lung Disease Intestinal Problems
 Kidney or Bladder Disease Cancer =>type: _____ Other serious Illness: _____

Have you ever had any other accidents prior to this injury, if so list dates: (including auto, sports, injuries/accidents around the home or at work, also list any broken bones): _____

Allergies: NONE Aspirin Tetanus Toxioid Tetracycline Codine Penicillan Dusts Cats Pollen Grass Foods
 Other: _____

List all surgeries and hospitalizations from birth up to today: _____

FAMILY HISTORY

Age	Current state of health	Living/Deceased	Age	Current state of health	Living/Deceased
Mother: _____	_____	_____	Father: _____	_____	_____

Family History: List any conditions that your mother, father or any other relative has had which may include but is not limited to: Arthritis, Diabetes, Cancer, Heart Disease, Hypertension, Peptic Ulcer, Tuberculosis, Ankylosing Spondylitis, Multiple Sclerosis, Etc.

INSURANCE INFORMATION

Payment will be made today by: Cash Check Credit Card

Do you have medical insurance? No Yes. If yes see below.

We will need to make a photocopy of your *Insurance Card -&- Drivers License.*

If you are not the primary insured or the policy holder then we will need the following information.

Name of insured: _____ S.S. # of Insured: _____ - _____ - _____

Insured's Date Of Birth: ____/____/____ Insured Employers Name: _____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office 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 the Doctor's Office will be credited to my account on receipt. If a check goes to the Doctor's Office with my name on the check, I authorize Power of Attorney to sign my name so that the check can be deposited and credited to my account. 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, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Person or Persons Assisting Patient: _____ Date: _____

Thank you!! And again, we look forward to a healthy relationship with you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE – “AOR”

What is HIPAA Administrative Simplification?

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. In a nutshell, we are ordered to make sure all possible measures are in place in order to protect your medical information here in this office. Your medical file / information will not be given out to anyone without your consent. Other forms of protection are also implemented in order to protect your privacy as outlined in the “NOTICE OF PRIVACY PRACTICES.”

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Renfro Chiropractic’s “NOTICE OF PRIVACY PRACTICES,” revision dated April 13, 2003.

As required by the Privacy Regulations, Renfro Chiropractic has explained the “NOTICE OF PRIVACY PRACTICES,” to my satisfaction.

As required by the Privacy Regulations, I am aware that Renfro Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.

I acknowledge that I received a copy of *Renfro Chiropractic* “NOTICE OF PRIVACY PRACTICES,” revision dated April 13, 2003.

Patient name (print) _____

Signature _____ Date _____

Signed form received by: _____ Date: _____

If Patient Refuses to sign place an “X” on this line: _____

Renfro Chiropractic
206 N. Euclid St.
Fullerton, CA. 92832
714-526-9355

**INFORMED CONSENT FOR CHIROPRACTIC
TREATMENT AND CARE**

I hereby request and consent to the performance of chiropractic adjustments, massage and other chiropractic procedures, including various modes of physiotherapy including massage therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with Renfro Chiropractic

I understand that, as in the practice of medicine, in the practice of chiropractic care and massage there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with Renfro Chiropractic to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name (Please Print)

Date

Patient or Guardian's Signature

STOP
You Are Finished ☺
Return Forms to the Front Desk