Miller Chiropractic Center
PATIENT INTAKE

206 N. Grimmell Rd
Jefferson, Iowa 50129
Phone: (515) 386-2515
Fax: (515) 386-4286

CONFIDENTIAL PATIENT CASE HISTORY

Today's Date_____

Name _____ Nickname_____ Date of Birth _____
Gender ❑ M ❑F ❑ Other
Home Address _____City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Marital Status S M P W D Sep Spouse/Partner's Name _____
Employer _____ Occupation _____
Employer Address _____ City _____ State _____ Zip_____
Email _____
Whom may we thank for referring you to our office? _____

In case of emergency who should we contact?
Name_____ Relationship_____
Phone Number _____

REASON FOR SEEKING CHIROPRACTIC CARE

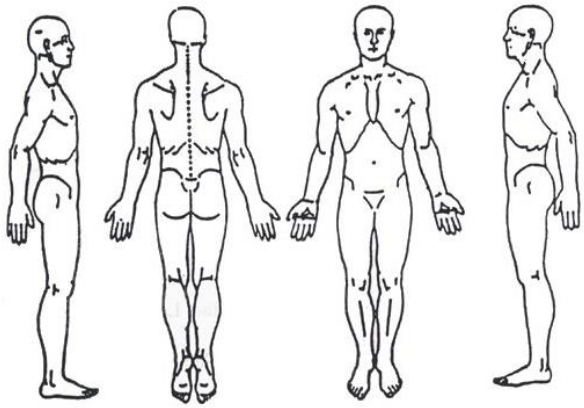
Please list below any complaint(s) that Miller Chiropractic Center can address for you?

1. _____How long? _____ 3. _____How long? _____

2. _____How long? _____ 4. _____How long? _____

On the diagram, please circle the area(s) where you experience present complaints. Then, f*or each area that you have circled*, **designate a number from 0-10** (***with 10 being the most pain***) that corresponds to your *current* pain level.

0-10	Burning	Dull	Sharp	Numb	Tingling	Ache	Other
___Headache	❑	❑	❑	❑	❑	❑	❑
___Neck	❑	❑	❑	❑	❑	❑	❑
___Shoulder	❑	❑	❑	❑	❑	❑	❑
___Mid Back	❑	❑	❑	❑	❑	❑	❑
___Elbow	❑	❑	❑	❑	❑	❑	❑
___Wrist	❑	❑	❑	❑	❑	❑	❑
___Low Back	❑	❑	❑	❑	❑	❑	❑
___Hip	❑	❑	❑	❑	❑	❑	❑
___Knee	❑	❑	❑	❑	❑	❑	❑
___Ankle	❑	❑	❑	❑	❑	❑	❑
___Foot	❑	❑	❑	❑	❑	❑	❑
___Other_____	❑	❑	❑	❑	❑	❑	❑



Has this condition: ____gotten worse ____ stayed constant ____ occurred ON and OFF
Has this condition occurred before? ❑YES ❑NO
Explain_____
What activities aggravate your condition?_____
What makes your condition better?_____
Why do you think this condition is not getting better on its own? _____
Do any symptoms travel to arms/legs/hands/feet? ❑Yes ❑No If yes, please describe:

❑Tingling ❑Numbness ❑Pain ❑Other, describe_____

CONFIDENTIAL PATIENT HISTORY FOR_____DATE___/_____/_____

Does this interfere with (check all that apply)

❑ Work/School ❑ Attention/Focus ❑ Daily Routine
❑ Exercise/Sports Walking ❑ Communication
❑ Sleep ❑ Eating

Explain_____

If you have no symptoms or complaints, and here for ***wellness services***, please check here: _____

HEALTH CARE PRACTITIONER HISTORY

Have you seen other doctors for this condition?
❑ YES ❑ NO
List previous diagnoses you have received for your present condition_____
Dr's Name(s)_____

Type of treatment_____
Result of care_____

Have you ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____
Reason _____ How long? _____ Date of last visit _____
Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers?
Check all that applies ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

HEALTH HISTORY

Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care.

Family History: Check the following condition that applies to you, or a member of your family

	You	*Mother*	*Father*	*Grandparent*	*Explain*
❑ Cancer	❑	❑	❑	❑	_____
❑ Diabetes	❑	❑	❑	❑	_____
❑ Heart Disease	❑	❑	❑	❑	_____
❑ HIV/ AIDS	❑	❑	❑	❑	_____
❑ Multiple Sclerosis	❑	❑	❑	❑	_____
❑ Pace Maker	❑	❑	❑	❑	_____
❑ Autoimmune Disease (ie RA, SLE)	❑	❑	❑	❑	_____
❑ Stroke	❑	❑	❑	❑	_____

List any surgeries you have had

1._____ Date:_____ 3._____ Date:_____
2._____ Date:_____ 4._____ Date:_____

List any hospitalizations (besides surgeries) you have had

1._____ Date:_____ 3._____ Date:_____
2._____ Date:_____ 4._____ Date:_____

Have you ever:	Yes	No	Describe briefly:
Had a fracture or broken bone?	❑	❑	_____
Been knocked unconscious?	❑	❑	_____
Been treated for a spine/nerve disorder?	❑	❑	_____
Used a crutch, cane, or other support?	❑	❑	_____

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List any traumas (even minor) including **car accident**, work, falls, injuries, etc. (please include approx. date)

_____

_____

P-Previous C-Current

P C

General

❑ ❑Allergy/Hay fever
❑ ❑Convulsions/Tremors
❑ ❑Dizziness
❑ ❑Depression/Anxiety
❑ ❑Fainting
❑ ❑Insomnia
❑ ❑Loss of Weight
❑ ❑Night Sweats

Muscle &Joint

❑ ❑Arthritis
❑ ❑Bursitis/Swollen Joints
❑ ❑Night Pain
❑ ❑Muscle Cramps at Night
❑ ❑Muscle Weakness
❑ ❑Scoliosis
❑ ❑Stiffness
❑ ❑Surgical Implant

Gastro-Intestional

❑ ❑Belching or Gas
❑ ❑Bloating After Meals
❑ ❑Constipation/Diarrhea

P C

❑ ❑Gall Bladder Removed
❑ ❑Colitis

EENT

❑ ❑Deviated Septum
❑ ❑Frequent Colds/Ear Infections
❑ ❑Nosebleeds
❑ ❑Tinnitus (ear ringing)
❑ ❑Headaches

Endocrine

❑ ❑Afternoon Headaches
❑ ❑Crave Salt
❑ ❑Coarse or Thinning Hair
❑ ❑Get “Shaky” if Hungry
❑ ❑Inability to concentrate
❑ ❑Increase in Weight
❑ ❑Sensitive to Cold
❑ ❑Hungry with no Weight Gain

Skin

❑ ❑Bruise Easily
❑ ❑Hives/ Rash

Cardio-Vascular

❑ ❑Asthma

P C

❑ ❑Chest Pain
❑ ❑Chronic Cough
❑ ❑Difficulty Breathing/Wheezing
❑ ❑Hardening of Arteries
❑ ❑High/Low Blood Pressure
❑ ❑Pain over Heart/Chest
❑ ❑Spitting up Blood/Phlegm
❑ ❑Swelling of Ankles

Genito-Urinary

❑ ❑Excessive/Little Urination
❑ ❑Bladder trouble
❑ ❑Painful Urination
❑ ❑Frequent Urination
❑ ❑Prostate Trouble

For Women Only

❑ ❑Hot flashes
❑ ❑Irregular/Painful/Excessive menses
❑ ❑Painful breasts
❑ ❑Premenstrual tension
❑ Yes ❑No Are you pregnant? How Many Weeks_____
Last Menstrual Period _____

WELLNESS PROFILE

How much water do you drink?_____
How frequently do you eat per day? 1-2meals 3-4 meals 5-6 meals snack all day

Drink soda? (Diet or regular) Yes No
How much caffeine do you have?_____
How frequently do you take over the counter medication? _____What do you take?_____

_____

How do you spend the majority of the day? **Seated** **Standing** **Other**_____
Computer/TV use: <30 min/day 30-60 min/day 2hr/day 3hr/day >4hr/day

Habits:	Heavy	Moderate	Light	None	Comments:
Alcohol	❑	❑	❑	❑	_____
Coffee	❑	❑	❑	❑	_____
Tobacco	❑	❑	❑	❑	_____
Drugs	❑	❑	❑	❑	_____
Exercise	❑	❑	❑	❑	_____
Appetite	❑	❑	❑	❑	_____

Rate these following on a scale 1-10 (10 being excellent):

Posture_____
Sleep_____ Hours per day?_____ Position?_____
Physical activity_____
How well do you handle stress? _____

Your stress level_____
Daily positive thinking_____
Taking time for yourself_____
Doing things you love_____

Age of your mattress_____ Type of mattress_____ ❑Comfortable ❑Uncomfortable
Are you wearing ❑Heel lifts ❑Arch supports

CONFIDENTIAL PATIENT HISTORY FOR_____DATE___/_____/_____

MEDICATIONS

List all medications you presently take, including dosages and frequencies _____

_____

_____

_____

_____

Do You	Y	N	
Now take vitamins, minerals, or herbs?	❑	❑	_____
Think you may need supplements?	❑	❑	_____
Have an allergy to any drug?	❑	❑	_____

Height: _____
Weight: _____

Any other Additional Information:

_____
_____
_____
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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please review it carefully.

A signed consent form permits us to use your personal health information within our office for the purposes of treatment, receiving payment, and health care operations of our practice.
It is the policy of this practice to release only the minimum necessary information to any source not directly linked to hands on care and treatment of patients in our office as outlined in the Health Insurance Portability Accountability Act of 1996 (HIPAA).
This includes third party payers, insurance companies, etc. In these cases your signed consent form permits us to release only enough information to complete the insurance claim process.
In some cases, patients may wish to have their protected health information released. In those cases if the outside entity can provide us with a copy of a medical records release form signed by the patient then we will comply while still providing only the minimum necessary information, or the amount of information requested by the patient.
In cases of public health, HIPAA does not protect some information. Where we are required by law to release information to any law enforcement or public health agency, our office will only release the minimum information required by law to any outside entity. In all cases we will follow the most restrictive laws, state or federal, that apply in protecting your medical information.
You, as a patient have a right to see your medical record during normal office hours.

ADDITIONAL USES OF YOUR HEALTH INFORMATION

Our staff may use your health information to remind you of appointments, send birthday or seasonal greeting cards, mailings, newsletters, information about our practice or other information we feel you may be interested in or may improve your health. We will not release a mailing list to any outside entity for solicitation of business not related to our office.

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason.
This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice.
HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read.
You have the right to revoke, in writing, this consent form at any time, although any services performed prior to the revocation of this consent are covered by this consent.

Patient Signature: _____Date:_____

Restrictions:

You have my permission to share PHI with the following people:

Name _____ Relationship: _____
Name _____ Relationship: _____
Name _____ Relationship: _____
Name _____ Relationship: _____

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our office's policies and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor/Staff Signature: _____Date: _____

Consent Agreement

Consent for Treatment
I understand that my outpatient registration, treatment or series of treatments by Miller Chiropractic Center, Inc. is necessary because of my condition. I voluntarily authorize and consent to the usual examination and treatments ordered by the Doctor and staff, including documentation and recording of history and examination.

Consent for treatment of a Minor
I (We) being the parent, guardian, or custodians of _____,
a minor, the age of _____, do hereby authorize, request and direct the Doctor/staff to perform in his/her judgment and necessary examinations, x-rays and recommended treatment for the condition.

Request for Records
I hereby authorize Miller Chiropractic Center, Inc. to request any medical records, x-rays, and specialized testing results, including serum and tissue testing results for the purpose of giving a better diagnostic picture. I permit a copy of this authorization to be used in requesting my records from any and all health care facilities, Physician, and health care providers.

Payment & Insurance Release
I permit a copy of this authorization to be used in place of the original by Miller Chiropractic Center, Inc. I authorize release to the Health Care Financing Administration and its agents any information needed to determine these benefits are payable.

I authorize any holder of medical information about me to be released to any of the above named health insurance or their contracted claims paying agents, and all information necessary to determine if these benefits are payable.

I authorize payments of medical benefits to this office.

When I pay by check, I expressly authorize this provider, if my check is dishonored or returned for any reason, to debit my account for the amount of the check plus a processing fee of $25.00 plus any applicable sales tax. The use of a check for payment is my acknowledgment and acceptance of this policy and its terms.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. However, I also understand and agree that all services rendered me are charged directly to me and services rendered me will be immediately due and payable. I further agree and understand that if the need arises, accounts delinquent by 90 days may be placed into legal collection agency. I understand and agree that I am responsible for all court cost, collection agency fee, filing fees and attorney fees that are incurred to collect my debt.

_____ _____
Date Patient's Signature

_____ _____
Witnessed by: Patient/Guardian's Signature-if applicable