

# Miller Chiropractic Center

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

## CONFIDENTIAL PATIENT CASE HISTORY FORM

### PERSONAL INFORMATION

Today's Date \_\_\_\_\_

Full Name: \_\_\_\_\_ Nickname \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Gender:  M  F Marital Status: S M P W D Sep Spouse/Partner Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Were you referred to our office?  Yes  No Your relationship to person referring: \_\_\_\_\_

In case of emergency who should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_

### REASON FOR SEEKING CHIROPRACTIC CARE

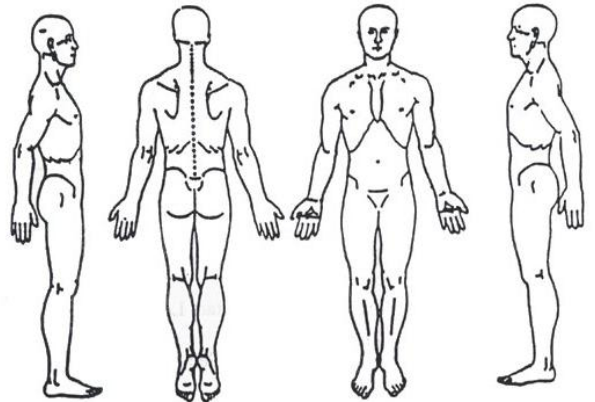
If you have no symptoms or complaints, and are here for *wellness services*, please check here: \_\_\_\_\_

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 current complaints. Then, *for 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.

<b>0-10</b>	<b>Burning</b>	<b>Dull</b>	<b>Sharp</b>	<b>Numb</b>	<b>Tingling</b>	<b>Ache</b>	<b>Other</b>
___ Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Mid Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Low Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Has this condition:  gotten worse  stayed constant  occurred on again/off again

Has this condition occurred before?  Yes  No

Explain: \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

CONFIDENTIAL PATIENT HISTORY FOR \_\_\_\_\_ DATE \_\_\_ / \_\_\_ / \_\_\_

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): \_\_\_\_\_

Does this interfere with (check all that apply):

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

Explain \_\_\_\_\_

### HEALTH CARE PRACTITIONER HISTORY

Have you seen other doctors for this condition?  Yes  No

Doctor's Name(s): \_\_\_\_\_

List previous diagnoses you have received for your present condition: \_\_\_\_\_

Type of treatment: \_\_\_\_\_

Result of care: \_\_\_\_\_

Have you ever received chiropractic care?  Yes  No Name of D.C. \_\_\_\_\_

Reason for care: \_\_\_\_\_

Duration of care: \_\_\_\_\_ 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(s) that applies to you, or a member of your family.**

	You	Mother	Father	Grandparent	Explain
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> HIV/ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Autoimmune Disease (i.e. RA, SLE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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: \_\_\_\_\_





## 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 (PHI) 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 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent/Guardian Signature (if minor)

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.

## 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 the 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 check amount 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 costs, collection agency fee, filing fees and attorney fees that are incurred to collect my debt.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent/Guardian Signature (if minor)