PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

DOB: _____ **Gender:** M / F **SSN:** _____ **Email:** _____

Address: _____ **Apt:** ____ **City:** _____ **State:** _____ **Zip:** _____

Mobile Phone: _____ **Home Phone:** _____

Job Status: Not Employed / Employed / Part-time Student / Full-time Student **Employer:** _____

Marital Status: Single / Married / Other

Who may we thank for referring you to our office? _____

Preferred Language: English / Spanish / Other: _____ **Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / Decline

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

Smoking Status: Everyday / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Name: _____ **Primary Care Physician:** _____

Phone: _____ **Doctor's Office:** _____

Relationship: Child / Parent / Spouse / Other: _____ **May we send health updates to this physician?** Y / N

FINANCIAL INFORMATION

Is today's visit the result of an accident? No / Auto / Work / Other _____

Will we be working with Insurance? No / Yes *(Complete Details Below)*

PRIMARY INSURANCE

Insurance Carrier: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____

DOB: _____ **Gender:** M / F

SECONDARY INSURANCE

Insurance Carrier: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____

DOB: _____ **Gender:** M / F

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

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

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint(s): _____

Secondary Complaint(s): _____

When did this start? _____ **How did this start?** _____

_____

MAJOR COMPLAINT

Grade Intensity/Severity

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency

- ☐ Off & On
- ☐ Constant

Quality

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

- ☐ No
- ☐ Yes _____

Improves with:

- ☐ Nothing
- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Movement
- ☐ Other: _____

Previous Treatment

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Neurologist _____
- ☐ Other: _____

Previous Diagnostic Testing

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

***Women:** *Are you pregnant?*

- ☐ No *Last Menstrual Period:* ___/___/___
- ☐ Yes *Due Date:* ___/___/___

Present Illness Comments:

_____

_____

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)*

_____

_____

_____

_____

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*

_____

_____

_____

_____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

Print Name *(First MI Last)* _____ Account # _____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder *(Type)* ____
- ☐ Blood Clots
- ☐ Cancer *(Type)* _____
- ☐ CVA/ TIA (Stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

Illnesses:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - o Shoulder – L / R _____
  - o Elbow/Forearm – L / R ____
  - o Wrist/Hand – L / R _____
  - o Hip – L / R _____
  - o Knee – L / R _____
  - o Ankle/Foot – L / R _____
- ☐ Spinal
  - o Neck: _____
  - o Back: _____
- ☐ Other: _____

_____

Medical History Comments:

_____

FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								

Family History Comments:

_____

SOCIAL AND OCCUPATIONAL HISTORY

Highest Level of Education:

☐ High School ☐ College ☐ Post Grad. ☐ Other

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise Frequency:

☐ Daily ☐ 3-4x/wk ☐ 2-3x/wk ☐ Rarely ☐ Never

Social History Comments: _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____

REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: _____
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _____
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: _____
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: _____
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: _____
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

Review of Systems Comments:

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I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature_____ Date _____

Print Name *(First MI Last)*_____ Account # _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your symptoms have 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

0	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Severely Disturbed Sleep	Totally Disturbed Sleep

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

0	1	2	3	4
No Pain; No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need assistance	Severe Pain Need 100% Assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on long trips	Mild pain on long trips	Moderate Pain on long trips	Moderate Pain on short trips	Severe Pain on short trips

5. Work

0	1	2	3	4
Can do usual work Plus extra work	Can do usual work No extra work	Can do 50% of Usual work	Can do 25% of Usual work	Cannot Work

6. Recreation

0	1	2	3	4
Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activites

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain 25% of day	Intermittent Pain 50% of day	Frequent Pain 75% of day	Constant Pain 100% of day

8. Lifting

0	1	2	3	4
No Pain with heavy weight	Increased Pain with heavy weight	Increased Pain with moderate weight	Increased Pain with light weight	Increased Pain with any weight

9. Walking

0	1	2	3	4
No Pain Any Distance	Increased Pain After 1 mile	Increased Pain After ½ mile	Increased Pain After ¼ mile	Increased pain With All Walking

10. Standing

0	1	2	3	4
No Pain After several hours	Increased Pain After several hours	Increased Pain After 1 hour	Increased Pain After ½ hour	Increased pain With Any Standing

Patient Signature _____ Date _____

Print Name _____ Total Score _____

Permenter Chiropractic

Notice of Privacy Practices

Effective January 1, 2016

Permenter Chiropractic (the "Practice"), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, (the "Privacy Rule") and applicable state law, is committed to protecting the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice. The Practice understands that information about your health is personal. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and practices with respect to your PHI. The Practice is also required by law to abide by the terms of this Notice.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible) by T. Jason Permenter, DC and/or other licensed doctors of chiropractic who now or in the future work at Permenter Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, VBA, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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 or Guardian Signature _____ Date _____

Print Name *(First MI Last)* _____ Account # _____

DO NOT WRITE IN THIS BOX

Patient Accepted?	YES	NO	Doctor's Signature _____

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