Chiropractic Case History/Patient Information

Date: _____ **File #**_____ **Doctor:** _____

Name: _____ *Social Security #*_____ *Home Phone:* _____ *Cell Phone:* _____ *Fax #* _____

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

E-mail address: _____ *Gender:* ___*Female* ___*Male*

Age: _____ *Birth Date:* _____ *Race:* _____

Marital Status: ___*Married* ___*Single* ___*Widowed* ___*Other:*_____

Occupation: _____ *Employer:* _____

Employer's Address: _____ *Office Phone:* _____ *Spouse:* _____ *Occupation:* _____ *Employer:* _____

How many children? _____ *Ages of Children:* _____

*Emergency Contact (relationship?):*_____ *Phone:* _____

*How were you referred to our office?*_____

Family Medical Doctor: _____

How would you like us to notify you of your future appointments? ___*Text Message* ___*Email* ___*Phone Call*

If you chose "Text Message", what is your carrier? ___*ATT* ___*Boost Mobile* ___*Cricket* ___*MetroPCS* ___*Nextol* ___*Sprint* ___*T-Mobile* ___*US Cellular* ___*Verizon* ___*Virgin Mobile* ___*Other:* _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Signature of Patient: _____ **Date:** _____

Signature of Legal Guardian: _____ **Date:** _____ **Relation:** _____

Pt. Name_____ **File #** _____ **Doctor** _____ **Date** _____

History of Present and Past Illness

Chief Complaint: Reason(s) for visit: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work___ Other _____

Have you ever had the same or a similar condition? ___ No ___Yes, please describe: _____

_____

Date of last physical examination: _____ *Days lost from work:* _____

Do you have a history of stroke or high blood pressure? ___No ___Yes, please describe: _____

Have you had any major illnesses? ___Cancer ___Diabetes ___Heart Disease ___Other: _____

Have you had any surgeries? ___No ___Yes, describe: _____

Have you been hospitalized? ___No ___Yes, describe: _____

Have you had any major injuries or falls? ___No ___Yes, describe: _____ *Have you been in any auto accidents? ___No ___Yes, describe:* _____

Have you been treated for any health condition by a physician in the last year? ___ No ___Yes

*If yes, describe:*_____

What medications or nutritional supplements are you taking? _____

_____

Have you used corticosteroids (Cortisone, Prednisone, etc.)? ___No ___Yes, describe: _____

Do you have allergies of any kind? ___No ___Yes

If yes, describe: _____

Do you have any Congenital Condition? ___No ___Yes, please describe: _____

***Women**: Are you pregnant? ___No ___Yes*

Please give information about any childbirths with dates: _____

SOCIAL HISTORY

What type of regular exercise do you perform? ___Light ___Moderate ___Vigorous ___None

How many 8 oz cups of water do you drink per day? ___1-2 ___3-4 ___5-6 ___7-8 ___9-10 ___other: ____

Do you drink caffeinated beverages? ___No ___Yes, drinks per day? ____ per week? ____ per month? ____

Are you on a special diet? ___No ___Yes, describe: _____

Do you drink alcohol? ___No ___Yes, drinks per day? ____ per week? ____ per month? ____

Do you use any recreational drugs? ___No ___Yes

Do you use tobacco of any kind? ___Never ___In the past ___Current tobacco user (__often or __sometimes)

How many hours of sleep are you getting per night? ___less than 5 ___6-8 ___8-10 ___10 or more

How would you rate your sleep? ___wake fully rested ___wake moderately rested ___wake poorly rested

How would you rate your stress level (please circle)? No Stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressed

List your major stressors: _____

What are your health goals? _____

Pt. Name _____ **File #** _____ **Doctor** _____ **Date** _____

Family History

Please indicate if an immediate family member has had any of the following:

Cancer – list family member(s) and describe: _____

Heart Problems – list family member(s) and describe: _____

Diabetes – list family member(s) and describe: _____

Other – list family member(s) and describe: _____

Review of Systems

Please indicate if you have any of the following with:
N = *NOW* **P**= *PREVIOUSLY*

Constitutional	*__none __chills __daytime drowsiness __fatigue __fever __loss of appetite __night sweats __weight gain / loss __fainting __excessive thirst __headaches __frequent urination __other: _____*
Eyes, Vision	*__none __blind spots __cataracts __double vision __wears contacts / glasses __itching __tearing __other: _____*
Ears, Nose, Throat	*__none __nosebleeds __ear discharge __loss of smell __dizziness __runny nose __hearing loss __nasal congestion __headaches __sinus pain __ear pain __history of head injury __sore throat __loss of taste __other: _____*
Respiratory	*__none __sputum production __asthma __shortness of breath __cough __coughing up blood __wheezing __other: _____*
Cardiovascular	*__none __high blood pressure __heart attack __stroke __Pacemaker __low blood pressure __circulation issues __heart disease __heart murmur __chest pains/tightness __palpitations __other: _____*
Gastrointestinal	*__none __diarrhea __constipation __abdomen pain __loss of appetite __ulcers __jaundice __indigestion __abnormal stool __difficulty swallowing __belching __heartburn __hemorrhoids __rectal bleeding __gallbladder issues __liver issues __other: _____*
Female	*__none __on birth control __menstrual difficulties __kidney or bladder issues __hormone therapy __menopause __other: _____*
Male	*__none __kidney issues __bladder issues __prostate problems __other: _____*
Skin	*__none __itching __lesions/ulcers __numbness __rash __shingles __hives __bruises __skin disorder __hair loss __other: _____*
Neurologic	*__none __numbness __memory loss __stroke __dizziness __weakness __balance loss __fainting __headache __seizures __sleep disturbance __other: _____*
Psychologic	*__none __confusion __loss of appetite __memory loss __anxiety __insomnia __mood change __eating disorder __stress __depression __nervousness __other: _____*
Hematologic	*__none __bleeding __blood clotting __blood transfusion __anemia __fatigue __bruise easily __lymph node swelling __other: _____*
Musculoskeletal	*__none __arthritis __Rheumatoid arthritis __joint pain/swelling __osteoporosis (weak bones) __other: _____*

I certify the information provided is accurate to the best of my knowledge:

Name of Patient(print): _____

Signature of Patient: _____ **Date:** _____

Signature of Legal Guardian: _____ **Date:** _____ **Relation:** _____

INFORMED CONSENT
TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me, _____ by Brian J. Wirth, D.C. and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Brian J. Wirth, D.C. and/or other licensed Physician of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Wirth and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of all healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:

_____

Please Print Your Name

_____

Please Sign Your Name

INFORMED CONSENT
TO
CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, onthe patient named below, for whom I am legally responsible: _____ by Brian J. Wirth, D.C. and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Brian J. Wirth, D.C. and/or other licensed Physician of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Wirth and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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To be completed by the patient's representative, if necessary, (e.g. If the patient is a minor or is physically or mentally incapacitated)

_____

Print Name of Patient

_____

Relationship to Patient

_____

Signature of Representative

WIRTH CHIROPRACTIC

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information. We may have to disclose your health information to another care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of you health condition. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. We may need to use your health information within our practice for quality control or other operational purposes.

We have a complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time, however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Patient Name (Print) *Date*

_____ *Dr. Brian Wirth*

Patient Signature *Authorized Provider Representative*

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____ Print Patient's Name_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

X-RAY CONSENT

Wirth Chiropractic
303 Plaza Dr.
Greenville, NC 27858
1-800-BACK- DOC

I _____ (name of person being treated) hereby acknowledge that Dr. Brian Wirth of Active Living Chiropractic has informed me of the advisability of, risk, inherent in, and the probable consequences of X-rays. He has explained to me the reasons and need for such x-rays. With my understanding I am giving Dr. Brian Wirth my consent to take X-rays.

Date_____

Patient Signature_____