Case History/Patient Information

Name:_____

Address:_____State:_____Zip:_____

Cell #:_____Work#:_____ DOB:_____

Email:_____ Status: M / S / W / D

SSN:_____-_____-_____**Referred by**:_____

Primary Insurance:_____Secondary:_____

Occupation:_____Employer:_____Status: Employed / Unemployed / Student

How may we contact you? Email Cell Text Mail Other:_____

Emergency Contact: _____Cell #:_____

Financially Responsibility and Assignment of Benefits: I hereby sign, transfer, and set over to this office all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize payment of insurance benefits directly to the office. I authorize the release of any medical information needed to determine these benefits. 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. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am responsible for all costs of 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.

C**onsent Form for Therapy**

1. I, the undersigned, do hereby agree and give consent for medical care and treatment necessary in treating my physical condition.
2. I further acknowledge that the purpose of the care, risks of the recommended care and the risks of foregoing this care have been fully explained to and understood by me.
3. I recognize that the practice of therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy.
4. I also recognize that therapy care may involve the touching of my body by members of the Clinic's professional staff and that full or partial disrobing may be required to facilitate such care, all of which is expressly consented to by me.
5. I agree to cooperate fully and to participate in all therapy care procedures, to comply with the plan of care as it is established and to pay Clinic's charges for such care upon my receipt of Clinic's invoice for such care.

The patient understands and agrees to allow this office to use their **Patent Health Information** for the purpose of treatment, payment, healthcare operations, and coordination of care. We encourage you to read the HIPAA Notice that is available to you at the front desk before signing the consent.

The office has permission to discuss health information to the following: SPOUSE SON/DAUGHTER MOTHER FATHER

List names and others: _____

I have read the above and I certify that I have had an opportunity to discuss the contents thereof to my satisfaction. By signing below, I am hereby consenting to the therapy care and financially responsibility as described above.

Patient Signature: _____Date:_____

Guardian Signature Authorizing Care: _____ Date: _____

Office Staff Signature:_____Date:_____

History of Injury

Chief complaint: _____When did it start: _____

Location: _____Is it? □Dull □Sharp □ Burning □Tingling □Throbbing □Numbness □Stabbing□ Other_____

What may have caused this? _____Severity Scale (circle one below 1-10)

Was the onset? □ Gradual □ Sudden □ Other:_____ Mild 1 2 3 4 5 6 7 8 9 10 Severe

What makes it worse? _____ What makes it better? _____

Any prior treatment? _____Have you had this before? □ Yes _____ □ No

What does this interfere with? _____

2nd complaint: _____When did it start: _____

Location: _____Is it? □Dull □Sharp □ Burning □Tingling □Throbbing □Numbness □Stabbing□ Other_____

What may have caused this? _____Severity Scale (circle one below 1-10)

Was the onset? □ Gradual □ Sudden □ Other:_____ Mild 1 2 3 4 5 6 7 8 9 10 Severe

What makes it worse? _____ What makes it better? _____

Any prior treatment? _____Have you had this before? □ Yes _____ □ No

What does this interfere with? _____

3rd complaint: _____When did it start: _____

Location: _____Is it? □Dull □Sharp □ Burning □Tingling □Throbbing □Numbness □Stabbing□ Other_____

What may have caused this? _____Severity Scale (circle one below 1-10)

Was the onset? □ Gradual □ Sudden □ Other:_____ Mild 1 2 3 4 5 6 7 8 9 10 Severe

What makes it worse? _____ What makes it better? _____

Any prior treatment? _____Have you had this before? □ Yes _____ □ No

What does this interfere with? _____

4th complaint: _____When did it start: _____

Location: _____Is it? □Dull □Sharp □ Burning □Tingling □Throbbing □Numbness □Stabbing□ Other_____

What may have caused this? _____Severity Scale (circle one below 1-10)

Was the onset? □ Gradual □ Sudden □ Other:_____ Mild 1 2 3 4 5 6 7 8 9 10 Severe

What makes it worse? _____ What makes it better? _____

Any prior treatment? _____Have you had this before? □ Yes _____ □ No

What does this interfere with? _____

Review of Systems

Check below if you have **now** or have had **previously- mark with N for Now and P for previous condition**

Musculoskeletal	**P/N**
Osteoporosis	
Arthritis	
Scoliosis	
Neck Pain	
Hip Disorder	
Knee Injury	
Foot/ankle Pain	
Shoulder Pain	
Elbow/wrist Pain	
TMJ issues	
Poor Posture	

Psych/Neuro	**P/N**
Anxiety	
Depression	
Memory Loss	
Loss of sleep	
Headache	
Dizziness	
Pins/needles	
Numbness	
Loss of smell	
Loss of taste	

Eye/ENT	**P/N**
Dimension Changes	
Blurred Vision	
Double Vision	
Earache	
Hearing Loss	
Ringing in ears	
Ear infections	
Hoarseness	
Sore Throat	
Difficulty Swallowing	

Cardiovascular	**P/N**
Chest pain	
Palpitations	
Shortness of breath	
Lightheadedness	
Hypertension	
hypotension	
High Cholesterol	
Ankle Swelling	

Respiratory	**P/N**
Cough	
Short breath	
Asthma	
Emphysema	
Hay Fever	
Pneumonia	
Wheezing	

Gastrointestinal	**P/N**
Nausea	
Vomiting	
Abdominal Pain	
Heartburn	
Ulcer	
Food Sensitivity	
Changes in bowel	
Constipation	
Diarrhea	
Blood in stool	

Geniturinary	**P/N**
Painful urination	
Frequent urination	
Urgency	
Incontinence	
Immunology	
Autoimmune	
Immune defiency	

Endocrine	**P/N**
Diabetes	
Hot Intolerance	
Cold intolerance	
Hyperthyroid	
Hypothyroid	
Pancreatic condition	
Excessive urine	
Increased thirst	

Derm/ Hemo	**P/N**
Rashes	
Hyper pigmentation	
Hypo pigmentation	
Excessive acne	
Eczema	
Psoriasis	
Skin Cancer	
Excessive hair loss	
Easy Bruising	
Bleeding gums	

Contraindications: Check yes or no

Relative	**Y**	**N**	**Absolute**	**Y**	**N**		**Y**	**N**
Articular Hypermobility Disease			Rheumatoid Arthritis			Fracture		
Severe Demineralization of Bone			Ankylosing Spondylitis			Myelopathy		
Benign Bone Tumor (spine)			Dislocation:			Cuada Equina		
Bleeding disorder			Unstable Os Odontoedeum			Vertebrobasilar		
Are you on an anti-coagulant?			Malignancies in spine			Aneurysm		

Past History/Family/Social

Surgeries: _____

_____

Illnesses: _____

_____

Accidents/Fractures: _____

_____

Are you currently taking any medications? ☐ No ☐ Yes (Please include regularly used over the counter medications)

Medication Name	For what use	Dosage and Frequency

Do you have any allergies? ☐ No ☐ Yes, If so list: _____

Family History of: ☐ Diabetes ☐ Cancer ☐ Hypertension ☐ Neurological ☐ Stroke ☐ Other: _____

Work: ☐ Full time □ Part-time □ Unemployed ☐ Retired ☐ Student ☐ Disabled Describe work: _____

Social: ☐ Alcohol amount: _____ □ Smoke # per day: _____ ☐ Caffeine # per day: _____ ☐ Recreational Drugs

Exercise: Daily / Few times a week / none **Type of Exercise**: _____

Diet: _____ **Cups of water per day**:_____

Supplements: _____

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

Patient Name – Print_____

Signature_____

Date_____