# INTRODUCTION PATIENT CASE HISTORY

**Today's Date: _____**

## PATIENT INFORMATION

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

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

**Home:** _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

**Email:** _____ **Gender:** M / F **Marital Status:** Married / Other / Single

**Social Security #**:_____ **Date of Birth:** _____

**Student Status:** Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** _____

***Referred By:** _____

**Ethnicity**: Hispanic or Latino / Other

**Preferred Language:** _____

**Race:** Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

**Smoking Status**: Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

**Full Name:** _____

**Primary Care Physician:** _____

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

**Doctor's Phone:** _____

**Relationship**: Child / Parent / Spouse / Other: _____

## FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):_____

**PRIMARY INSURANCE**

**Name:** _____

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

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

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

**Phone:** _____ **Date of Birth:** _____

**SECONDARY INSURANCE**

**Name:** _____

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

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

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

**Phone:** _____ **Date of Birth:** _____

**Who is responsible for payment?** Self / Other - *(Relationship)* _____

*Other than Self:*
**Full Name**: _____ **Phone:** _____

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

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

**Patient No:** _____

# PEDIATRIC CASE HISTORY

## HISTORY OF CURRENT CONDITION

**Describe Major Complaint:** _____

**Began When?** ____/_____/_____ **Describe how this began:**_____

_____

**Grade Intensity/Severity of Complaint:** None / Mild / Moderate / Severe / Very Severe

**How frequent is the complaint present?** Off & On / Constant

**Does anything make the complaint better?** _____

**Does anything make the complaint worse?** _____

**Which daily activities are being affected by this condition?** *(Describe)* _____

**For this CURRENT condition, have you:**

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____
- **Had any previous Surgery or Interventions in this area?** *(Describe)*_____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

**Describe any Secondary Complaints:** _____

## HEALTH HISTORY – (*PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED*)

***Medications:***

**Allergies to Medications:** ***NONE*** *(List)* _____

_____

**Current Medications:** ***NONE***

*(Over-the-counter or Prescription.)*_____

_____

_____

***Past Health History:*** *(Please list any past…)*

**Surgeries – Date, Type, and Reason:** ***NONE***

_____

_____

_____

**Major Injuries/Traumas:** ***NONE*** _____

_____

_____

**Major Hospitalizations:** ***NONE*** _____

_____

_____

***Family Health History:*** *(Please mark N/A if not relevant.)*

**List *relevant* major health problems of immediate relatives:**

_____

_____

_____

**Deaths in immediate family:** *(Cause and at what Age?)*

_____

_____

_____

***Prenatal History:*** *Home / Birthing Center / Hospital*

**Birth Weight**: _____ **Birth Length**: _____

**Interventions**: *NONE / Forceps / Vacuum / C-Section*

**Complications**: *NONE* / _____

**Medications during pregnancy**: *NONE* / _____

***Feeding and Development History:***

**Breast fed**: ☐ No ☐ Yes - *How long*? _____

**Formula**: ☐ No ☐ Yes - *What type*? _____

**Food allergies or intolerances**? : ☐ No ☐ Yes

*If yes, please describe:*_____

_____

**Rolling over**: ☐ No ☐ Yes **Sitting**: ☐ No ☐ Yes

**Crawling**: ☐ No ☐ Yes **Walking**: ☐ No ☐ Yes

**Sleep**: *Hours/night* _____ *Sleep well*: ☐ No ☐ Yes

**Childhood diseases**: ☐ None ☐ Chicken Pox ☐ Measles ☐ Meningitis ☐ Mumps ☐ Whooping Cough ☐ Rubella ☐ *Other*:_____

**Has child been vaccinated?** : ☐ No ☐ Yes

*Any adverse reactions?* : ☐ No ☐ Yes _____

***Social and Occupational History:***

**Level of Education Completed:** _____

**Lifestyle:** *(Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)*

_____

_____

_____

**Patient No:** _____

## Are you *currently* experiencing any of these symptoms? *(Check all the apply)*

## Many of the following conditions respond to Chiropractic and Acupuncture treatment.

**General:** *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

**Musculoskeletal:**
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

**Neurological:**
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other: _____
- ☐ *None in this Category*

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

**Genitourinary:**
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

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

**Cardiovascular & Heart:**
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

**Respiratory:**
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

**Eyes and Vision:**
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

**Ears, Nose and Throat:**
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

**Endocrine, Hematologic, and Lymphatic:**
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

**Skin and Breasts:**
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

**Women Only:**

**Are you pregnant?**
- ☐ **Yes -** ***Due Date*** __/____/____
- ☐ **No -** ***Last Menstrual Period*** __/____/____
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

***Pregnancies with Outcome & Date:***

_____

_____

_____

**Comments:** _____

_____

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

Patient or Guardian Signature _____ Date_____

Treating Doctor Signature _____ Date_____

**Patient No:** _____

# CONSENT FOR TREATMENT OF MINOR

Date: _____

I hereby authorize: _____Khanh Nguyen D.C._____
Doctor's Name

and whomever he or she may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

_____
Minor Patient's Name

_____
Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

Parent Remarks**:** _____

_____

_____

_____

# CONSENT FORM

## Consent to Examination and Treatment

By signing below, I give the doctor(s) and staff of Enlightened Chiropractic permission to perform all examinations, tests, treatments and anything else deemed necessary or beneficial to my care. I also understand that these actions will be performed by either the doctor or an assigned staff member of Enlightened Chiropractic. I further understand that all insurance payments made directly to this office will be credited to my account.

## Consent to Retrieve Medical Records

By signing below, I give the doctor(s) and staff of Enlightened Chiropractic permission to collect any and all medical records deemed necessary to assist with my care. This includes records from hospitals or any other provider of services which would be helpful in assisting in my case

## Consent to Release of Medical Records

By signing below, I give the doctor(s) and staff of Enlightened Chiropractic permission to disclose all or any part of my record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge. The includes, but is not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

## Consent to Receive Appointment Reminder by text message or email

I hereby give my consent to Enlightened Chiropractic to send text message/email reminders to my mobile telephone (as per the number and carrier I have listed). These messages will be a reminder of my previously booked appointment date and time, or a notification that I need to make an appointment for an adjustment. All patients have the right to stop this service. If you no longer wish to receive these text reminders, please notify our office. If you change your mobile number, please inform us to that we can update our records.

## Request Health Records

The patient has the right to obtain a one-time copy of his or her health records at any time. A fee of $25 will be charged and paid in advance by the patient for forms needed to be filled out by Dr. Nguyen that may fall outside the normal book keeping of this office. (I.e. AFLAC, FMLA, Disability, Social Security). The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of the PHI. Our office is not obligated to agree to these restrictions.

## Verification of Non-Pregnancy (Women Only)

By my signature below, I do hereby state that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

## Assignment and Conveyance of Lien Interest for Personal Injury Patients

(Motor Vehicle Accidents Only)

I hereby execute and provide an Irrevocable Lien interest and Assignment of proceeds to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance, policy to which I am entitled, and from which I am paid in the form of an insurance settlement(s), claim(s), judgments, or verdict(s) resulting from any identified accident. The insurance carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter

be paid directly to the above named doctor and or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney and I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment for all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s). The patient understands und agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest rate of 15% APR after 90 days from last date of service, which is the patient's responsibility for services past rendered. Payment for services rendered at due completion of these services, unless prior written arrangement is agreed upon.

**Assignment of Benefits for Insurance Purposes**

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance **DOES NOT** guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a daily basis as a courtesy to you. You will be responsible for your deductible and/or Co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours. The patient understands und agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Any unpaid bills will be charged an interest rate of 15% APR after 90 days from last date of service, which is the patient's responsibility for services past rendered. Payment for services rendered at due completion of these services, unless prior written arrangement is agreed upon.

**Clinical Summary Report (CCR)**

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Enlightened Chiropractic to save these electronically for me and not print them out after each visit. I understand that upon request these reports are available to be printed or emailed to me for review.

**Notice of Privacy Policy: Effective September 16, 2013**

By my signature below, I understand my HIPAA rights at Enlightened Chiropractic. Our office follows the privacy policy described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice. You can request a copy from the front desk.

**Please read the above statements and sign below.**

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____