INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

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

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

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

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

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

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

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

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

***Referred By:** *(Name):* _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

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

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

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:** _____

RESPONSIBLE PARTY

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

Other than Self:

Name: *(First MI Last)* _____

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

Phone: _____ **Email:** _____

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

Patient No: _____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

_____

_____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

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

Does this complaint radiate/shoot to any areas of your body? **No / Yes** *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

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 diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

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

Medications and Supplements:

Allergies to Medications: *NONE*

Name	Reaction

Current Medications & Supplements: *NONE*

Name	Dosage	Frequency	Method

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

Number of Falls in the last 24 months: _____ **Injuries?** Y or N

Surgeries: *NONE*

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: *NONE*

Date	Describe

Family Health History: *N/A*

List *relevant* major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

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
- ☐ 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:

Date	Outcome

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: _____

Chiropractic Wellness Center

2442 E 21st ST ▪ Tulsa, OK 74114 ▪ 918-742-0560

Exam and X-Ray Fees

Description of Service	Customary Charge	Initials
Examination & X-rays	$250.00	_____

I understand and agree that I will be responsible for the above charges if my insurance policy does not take care of them.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Dr. Hoose's Signature

Chiropractic Wellness Center PLLC
Dr Lance Hoose
2442 E 21st ST, Tulsa OK 74114
P (918)742-0560 F (918)742-0605

Health Insurance Portability & Accountability Act (HIPPA) Consent Form

Your protected health information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how you're Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent, and also may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the notice.

Requesting a restriction on the Use of Disclosure of Your Information

You may request a restriction on the use of disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information (PHI) for the purposes of treatment, payment or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Clinical Summary Report (CCR) for EHR

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 Chiropractic Wellness Center PLLC to save these electronically for me and not print them out after each visit. I understand that, upon request, that these reports are available to be printed or emailed to me for review.

Revocation of Consent (please check ONE box)

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

- ☐ I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.
- ☐ I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient signature: _____ Date: _____

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.

I, _____ (print) acknowledge, except and agree that I am responsible for my deductible and or Co-payment if not covered by my insurance company.

Signature:_____ Date: _____

Assignment and Conveyance of Lien Interest for Personal Injury Patients

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)

Patient Signature:_____ Date:_____

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of reaction due to ancillary procedures is also considered "rare".

Patient Signature:_____Date:_____