

CONFIDENTIAL ADULT PATIENT CASE HISTORY

Please complete this questionnaire fully. Your answers will help to determine how chiropractic care can help you.

PERSONAL INFORMATION:

First Name _____ Last Name _____ Middle Initial _____
What you prefer to be called _____
SS# _____ DOB _____
Address _____
City _____ State _____ Zip Code _____
Home phone _____ Work phone _____
Email address _____ Other phone _____
Occupation _____ Referred by _____
Status: _____ minor _____ single _____ married (children? ___ How many ___)
_____ Separated ___ Divorced _____ Widower
Spouse's Name _____ Child (ren's) Name/Ages _____
Emergency Contact: Name _____ Phone _____

Please initial here if we may add your email address to our mailing list for our Health & Wellness, monthly e-newsletter and occasional correspondence from this office with important updates/notices Yes, Please! _____

The human body is designed to be healthy. The primary system in the body which coordinates health is the nervous system. The healthy function of every cell, every system, every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect the central nervous system.

From the birth process until the present, events have occurred in your life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses common to our contemporary lifestyles can result in misalignment and damage to the spinal column. This interference is called the Vertebral Subluxation Complex.

The following form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your nervous system and therefore impair your inborn health and well-being.

HEALTH INFORMATION

Please specifically describe your reason for today's visit: _____

How did this happen: _____

When did this happen: _____

Is the pain getting worse: _____ yes ___ no ___ constant

Have you had this or similar conditions in the past: ___ yes ___ no

Please explain if yes: _____

How frequent is this pain becoming: _____

Has a medical doctor treated you for this: _____ yes ___ no

If so, whom and when: _____

Have you ever been treated by a Chiropractor: _____yes ____no

If so, whom and when: _____

Does this condition interfere with your: _____work _____sleep _____daily routine _____

Other (explain) _____

Are you currently under the care of a Medical Doctor for any condition ____Yes____No

If Yes, for what condition(s) _____

Please list any medications that you are taking such as: pain-killers, muscle relaxers, insulin, stimulants, birth control, anti-depressants, tranquilizers, nerve pills, behavioral, anti-inflammatories, blood-thinners, and/or cholesterol. _____

Do you take any supplements? N Y please list _____

How much water do you drink per day: _____oz

How much coffee or other caffeinated drinks do you have on a daily basis: _____

Do you smoke: _____Yes ____No How much _____cigarettes _____packs

Drink Alcohol? _____Yes ____No Glasses a day _____week _____

Do you have or have you had any of the following:

Please write C for current and P for past.

_____ Arthritis	_____ Kidney disease
_____ Asthma	_____ Seizures
_____ Diabetes	_____ Sinus problems
_____ Emphysema	_____ Thyroid disorder
_____ Gout	_____ Tuberculosis
_____ Heart disease	_____ Ulcers
_____ High blood pressure	_____ Cancer
_____ Carpal tunnel	_____ Headaches/migraines
_____ Numbness/tingling/hand/feet	
_____ Allergies	_____ Stroke
_____ Other _____	

Do you play sports/workout/exercise regularly?

Yes/No if yes, list _____

Are there any other health concerns you have? Yes No

(For Female Patients) Are you pregnant? ____Yes ____No

It is very important we know if you suspect you are pregnant, in the case we need to take x-rays today.

PREVIOUS HEALTH HISTORY

We have found that most chiropractic problems begin before the patient feels the first symptom. With that in mind, please take a moment to complete the following. *To the best of your knowledge*, did any of these apply to you?

Birth – 3 years:

Was yours a “difficult” birth? Yes No

Are you aware of any falls or traumas or health problems during these years?

4 - 6 years: Falls off a bike, injuries from “horseplay,” ect:

Are you aware of any falls or traumas or health problems during these years?

7 – 12 years: falls out of a tree, falls rollerblading/roller skating, etc.:

Are you aware of any falls or traumas or health problems during these years?

13 – 18: sports injuries, gymnastics, car accidents:

Are you aware of any falls or traumas or health problems during these years?

Childhood Illnesses: _____

Adulthood:

Any car accidents or accidents/falls of any kind:

Please list ALL Surgeries you have had since birth and other major medical procedures.

OFFICE POLICY:

Are you the person ultimately responsible for this account?

_____ Yes _____ No If no, who is _____

Address _____

Phone number _____

If you are filing this claim with your insurance, do you have your insurance card with you today? Yes No

If no, complete the following:

Company name: _____

Insured name: _____

Insured SS# _____ **DOB** _____

Group # _____ **Employer** _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If all charges are not paid when due, the undersigned agrees to pay costs of collections. Including 33 1/3% attorney's fees or other collection agency fees, PLUS INTEREST AT THE RATE CURRENTLY APPLICABLE BY VIRGINIA STATUTE TO JUDGEMENTS. It is agreed that any legal action for collections of monies due Rosemont Chiropractic, In Good Hands Chiropractic, Southeast Spine and Wellness or Olde Towne Family Chiropractic may be properly instituted in the courts of Virginia Beach, VA., and Virginia law shall apply.

Signature

Date

FINANCIAL AGREEMENT

Dear Patient:

Welcome! You have taken the first step on the path to optimal health. We take pride in delivering the finest in chiropractic care. The following payment options are available to help you handle your financial obligation.

We wish to make it very clear that your health is the sole responsibility of you the patient or your guardian.

I have elected to use the following payment plan to finance my care:

- _____ 1. CASH/CHECK/CREDIT CARD – Payment is due at the time of service, unless other payment arrangements have been made.**

- _____ 2. MEDICARE – I understand this office will complete all necessary Medicare forms on my behalf. However, I am responsible for any difference in payment that Medicare does not cover.**

- _____ 3. PERSONAL INJURY – Although my insurance or lawsuit may eventually pay for services rendered, I will pay this office \$50.00 toward my initial visit, and \$50.00 per week thereafter, until my balance is paid in full, whether active or inactive as a patient.**

- _____ 4. INSURANCE POLICY COVERAGE – although I am totally responsible for charges I may incur in this office, I will initially pay for my yearly deductible and the copayment agreed upon at the time of each visit unless my insurance fails to pay its share, at which time I will pay my balance in full.**

Please note: We will refund any overpayment made to this office.

PATIENT'S SIGNATURE _____

WITNESS _____ DATE _____

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at our office we may use or disclose personal and health related information about you in the following ways:

- * Your personal health information, including of your clinical records, may be disclosed to another health provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
 - * Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
 - * Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- * If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
 - * If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
 - * If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- * If we are providing health care services to you based on the orders of another health care provider.
- * If we provide health care services to you in an emergency.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:

Laura Jennejohn

If you would like further information about our privacy policies and practices please contact:
Laura Jennejohn

Name (Printed please)

Signature

Date

If you are a minor, or if you are being represented by another party

Personal Representative (Printed)

Personal Representative Signature

Date

Description of the authority to act on behalf of the patient.

**VERIFICATION OF NON-PREGNANCY
(Female Patients Only)**

Date: _____

Name: _____

Address: _____

Telephone: _____

Social Security #: _____

By my signature on this form, I, _____
do hereby state that, to the best of my knowledge, I am not pregnant nor is pregnancy suspected
or confirmed at this particular time.

Patient Signature: _____

Witness: _____