Case History Record

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Email Address _____

Age _____ Birthdate _____ Sex _____ Married __ S __ D __ W __ Children _____

Occupation _____ Referred By _____

Nearly all insurance companies cover chiropractic care. Does yours? _____

Name of insurance company _____ Policy no. _____

Address _____

Chief complaints: _____

Onset: Date _____ ❑ Gradual ❑ Sudden ❑ Progressive

Have you experienced this problem before? Y / N If yes, when _____

Has the problem: ❑ Improved ❑ Remained the same ❑ Worsened ❑ On & off

Mode of Onset: ❑ Auto ❑ Trip ❑ Fall ❑ Posture ❑ Unknown ❑ Other _____

Severity of problem: WORST 1 2 3 4 5 6 7 8 9 10 BEST

Duration of problem: _____ 25% of time _____ 25-50% of time _____ 50-75% of time _____ 75-100% of time

Character: ❑ Dull/Ache ❑ Sharp/Stabbing ❑ Burning ❑ Numbing/Tingling ❑ Throbbing

❑ Other _____

Relieving Factors: ❑ Rest ❑ Exercise ❑ Bracing ❑ Sitting ❑ Standing ❑ Lying ❑ Heat ❑ Ice ❑ Baths

❑ Other _____

Aggravating Factors: ❑ Coughing ❑ Sneezing ❑ Lifting ❑ Bending ❑ Sitting ❑ Reaching ❑ Standing

❑ Walking ❑ Running ❑ Driving ❑ Pushing ❑ Other _____

Are you presently taking medication? Y/N If yes, what _____

Have you ever seen a chiropractor? Y / N Who? _____ How long? _____

Previous Accident/Falls: _____

Previous Surgeries _____

Have you lost work days or stopped activities because of your pain? Y / N

Explain: _____

HAVE YOU HAD ANY DIFFICULTY WITH THE FOLLOWING?

HEAD: ❑ Headaches ❑ Dizziness ❑ Sinus ❑ Other_____

EYES: ❑ Glasses/Contact ❑ Pain ❑ Inflammation ❑ Other_____

EARS: ❑ Hearing ❑ Ringing ❑ Wax accumulation ❑ Pain ❑ Other_____

NOSE: ❑ Smell ❑ Hayfever ❑ Head colds ❑ Obstruction ❑ Other_____

THROAT: ❑ Speech ❑ Tightness ❑ Pain ❑ Tension ❑ Other_____

NECK: ❑ Stiffness ❑ Grating ❑ Pain ❑ Tension ❑ Other_____

RIGHT SHOULDER: ❑ Pain ❑ Stiff ❑ Bursitis ❑ Other_____

LEFT SHOULDER: ❑ Pain ❑ Stiff ❑ Bursitis ❑ Other_____

ARMS: ❑ R ❑ L **ELBOWS:** ❑ R ❑ L **WRISTS:** ❑ R ❑ L **HANDS:** ❑ R ❑ L

HEART: ❑ Pain ❑ Spasms ❑ Palpitation ❑ Attack ❑ Other_____

❑ High blood pressure: When?_____ ❑ Low blood pressure: When?_____

LUNGS: ❑ TB ❑ Pain around chest ❑ Intercostal neuritis ❑ Other_____

ABDOMEN: ❑ Stomach ❑ Liver ❑ Gallbladder ❑ Intestines ❑ Digestion ❑ Gas ❑ Constipation ❑ Diarrhea

❑ Kidneys ❑ Hemorrhoids ❑ Tenderness of abdomen ❑ Other_____

MENSTRUATION: ❑ Pain ❑ Cramping ❑ Irregularity ❑ Other_____

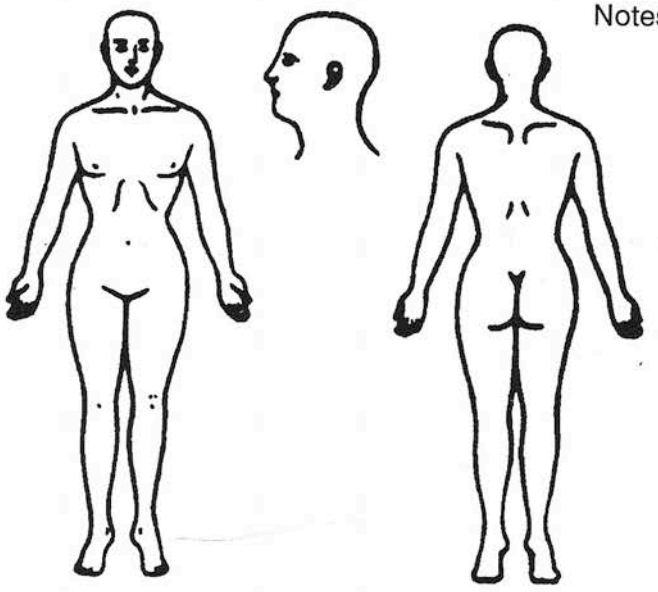
DO YOU HAVE: ❑ Inner tension ❑ Nervousness ❑ Diabetes ❑ Cancer ❑ Rheumatism ❑ Goiter ❑ Cramps

❑ Numbness in any body part ❑ Swelling ❑ Difficulty sleeping ❑ Anemia ❑ Fainting ❑ Weakness ❑ Arthritis

❑ Painful joints ❑ Swollen joints ❑ Pain in upper dorsal area ❑ Pain in lower dorsal area ❑ Pain in lower back

Pain in: ❑ Hip ❑ R ❑ L ❑ Thigh ❑ R ❑ L ❑ Knee ❑ R ❑ L

Pain in: ❑ Calf ❑ R ❑ L ❑ Ankle ❑ R ❑ L ❑ Foot ❑ R ❑ L



Notes:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby authorize the doctor to treat my condition as he seems appropriate through the use of adjustment throughout my spine.

Patient's Signature_____ Today's Date_____

The Doctor Patient Relationship In Chiropractic

Chiropractic

It is important to recognize the difference between chiropractic and medicine. Either can be important to your health, but for entirely different reasons. Chiropractors seek to restore health through natural means and without the use of medicine or surgery. The chiropractor's purpose is to restore health through the natural flow of energy in the nervous system. This gives the body maximum opportunity to heal itself. The success often depends upon underlying causes and conditions. It is important to understand the difference between chiropractic and medical services so that you, the patient, can determine whether either or both could benefit you.

Analysis

A chiropractor conducts a chiropractic analysis for the purpose of determining whether there is evidence of spinal subluxations. When such subluxations are detected, chiropractic adjustments are given to restore proper spinal alignment. It is the chiropractor promise that proper spinal alignment allows for free nerve flow throughout the body and gives the body its best chance to restore breath. Due to the complexities of nature, no chiropractor can promise specific results. This depends upon the recuperative powers of the body. Chiropractors are experts in chiropractic analysis. Internists are specialist in medical diagnosis. Each discipline requires its own experience and the patient should discuss with chiropractor the options involving the nature of his/her illness or injury.

Chiropractic Adjustments

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient in accordance with the chiropractic analysis. In some cases the underlying physical defects, deformities or pathology may render the patient susceptible to injury. It is therefore imperative that the patient makes it known whether he or she is suffering from latent pathological, illness, or deformity, which would otherwise not come to the attention of the chiropractor.

Results

The Doctor of Chiropractic provides a specialized health service, which is separate and distinct from the patient's medical regimen. Since each patient is different, it is difficult to predict the time schedule of recovery. Some patients will respond in a very short time. However, in most cases, recovery is very gradual. In a few cases, the patient's response may not be satisfactory to the chiropractor, and he may recommend discontinuous of his service.

Acknowledgement

I have read the foregoing and understand it.

_____ _____

Patient's Signature Date

Santo Family Chiropractic

Financial Policy

Payment for all services are due as they are rendered. We accept cash, personal checks and credit card for payment.

If you are a member of an insurer that we do not participate with, you will need to pay for your visit at time of service. We will submit the insurance claim for you. We will reimburse you for any fee adjustments and/or insurance payments. You may choose to file the insurance claim yourself. We will provide you with a "superbill" receipt which is accepted by most carriers.

If you have any questions regarding our policy, please discuss them with the office manager.

I have read and understand the above mentioned financial policy.

_____ _____

Patient Date

HIPAA HAPPENINGS

Santo Family Chiropractic Office, Inc.

Patient Authorization for appointment reminders and scheduling related matters

It is our desire to for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information use your decision will have no adverse effect on your care from _____ or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Name (printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Life Chiropractic College West, Gerard W. Clum, D.C., President
25001 Industrial Blvd., Hayward, CA 94545, Ph: 510-780-4500, x4550
Fax: 510-780-4515, Email: gclum@lifewest.edu

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 protected 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 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:

_____

If you would like further information about our privacy policies and practices please contact: Dr. Eric Santo

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.

_____ _____ _____

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.

Santo Family Chiropractic Office

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 Santo Family Chiropractic Office, Inc. 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 care 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 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 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 provide 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.
*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 judgement 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.