

INTRODUCTION PATIENT CASE HISTORY

Patient No: _____ Date: _____

Name (Mr. Mrs. Miss Ms.) _____
(Last, First, MI)

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Mobile: () _____ Work Phone: () _____

Email Address: _____ Married _____ Single _____ Other _____

Social Security No.: _____ - _____ - _____ Date of Birth: ____/____/____

Occupation: _____ Employer: _____

Name of your Insurance Company: _____

Primary Insurance Holder: _____ Primary Holders Date of Birth: _____

Previous Chiropractic Care? Yes No Doctor's Name: _____

Major Complaint: _____ Began When and How _____

Any Recent Surgeries _____ Any Recent Accident's _____

Medications _____ Allergies RX _____

Physicians Contact _____

Who (or what source) referred you? _____

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

Patient Health Questionnaire

Patient No. _____

Patient Name _____ Date _____

1. Describe your current symptoms (Begin with what bothers you the most) _____

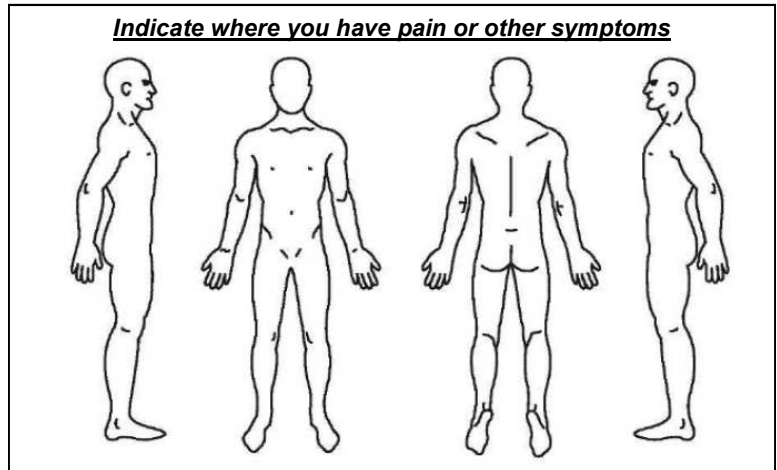
2. When did your symptoms begin? _____

3. What activities make your symptoms worse? (1) Ice (2) Heat (3) Rest (4) Activity (5) Sitting (6) Standing (7) Medication (8) Other

4. What activities make your symptoms better? (1) Ice (2) Heat (3) Rest (4) Activity (5) Sitting (6) Standing (7) Medication (8) Other

5. What describes the nature of your symptoms?

- (1) Sharp (4) Shooting
- (2) Dull Ache (5) Burning
- (3) Numb (6) Tingling



6. Draw the location of your symptoms on Diagram

7. What describes the severity of your symptoms?

None 1 2 3 4 5 6 7 8 9 10 Severe

8. How are your symptoms changing?

- (1) Getting Better
- (2) Not Changing
- (3) Getting Worse

9. Who else have you seen for your current symptoms?

- (1) No One (3) Medical Doctor (5) This Office
- (2) Other Chiropractor (4) Physical Therapist (6) Other: _____

10. What tests have you had for your symptoms?

- (0) None (1) X-rays date: _____ (3) CT Scan date: _____
- (2) MRI date: _____ (4) Other date: _____

11. What other forms of care have you tried for your current complaint?

- (1) Nothing (3) Muscle Relaxer (5) Advil/Tylenol/Aleve, etc (7) Injections
- (2) Pain Medication (4) Ice/Heat (6) Physical Therapy (8) Other: _____

12. What do you feel caused your symptoms? (1) Fall (3) Lifting (5) Work
(2) Car Accident (4) Don't Know (6) Other: _____

13. What activities are effected by your symptoms?

- (1) Work/School (3) Sleeping (5) Driving/Riding in Car (7) Golf (9) Exercising
- (2) Walking (4) Running (6) House Work (8) Yard Work (10) Other _____

14. Have you had similar symptoms in the past? (Y) Yes When? _____ (N) No

15. If yes, whom did you see? (1) No One (3) Medical Doctor (5) This Office
(2) Other Chiropractor (4) Physical Therapist (6) Other: _____

16. What is your occupation? (1) Professional/Executive (4) Laborer (7) Retired
(2) White Collar/Secretarial (5) Homemaker (8) Other: _____
(3) Tradesperson (6) F/T Student

17. What type of regular exercise do you perform? (1) None (2) Light (3) Moderate (4) Strenuous

For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past.

If you have the conditions listed, place a check in the PRESENT column.

Many of the following conditions respond to chiropractic and acupuncture

18.		19.									
PAST	PRESENT			PAST	PRESENT	PAST	PRESENT				
1	()	()	Headaches	21	()	()	High Blood Pressure	43	()	()	Diabetes
2	()	()	Neck Pain	22	()	()	Heart Attack	44	()	()	Excessive Thirst/Urination
3	()	()	Upper Back Pain	23	()	()	Chest Pains	45	()	()	Thyroid Disorder
4	()	()	Mid Back Pain	24	()	()	Stroke	46	()	()	Smoking/Tobacco Use
5	()	()	Low Back Pain	25	()	()	Angina	47	()	()	Drug/Alcohol Dependence
6	()	()	Shoulder Pain	26	()	()	Kidney Stones	48	()	()	Food Allergies
7	()	()	Elbow/Upper Arm Pain	27	()	()	Kidney Disorder	49	()	()	Depression
8	()	()	Wrist Pain	28	()	()	Bladder Infection	50	()	()	Frequent Illness
9	()	()	Hand Pain	29	()	()	Painful Urination	51	()	()	Epilepsy
				30	()	()	Loss of Bladder Control	52	()	()	Dermatitis/Eczema/Rash
10	()	()	Hip/Upper Leg Pain	31	()	()	Prostate Problems	53	()	()	HIV/AIDS
11	()	()	Knee/Lower Leg Pain								
12	()	()	Ankle/Foot Pain	32	()	()	Abnormal Weight Gain/Loss	Females Only			
				33	()	()	Loss of Appetite	54	()	()	Hot Flashes
13	()	()	Jaw Pain/TMJ	34	()	()	Abdominal Pain	55	()	()	Hormone Replacement
				35	()	()	Ulcer	56	()	()	Birth Control Pills
14	()	()	Joint Swelling/Stiffness	36	()	()	Hepatitis	57	()	()	Painful Periods/Cramps
15	()	()	Arthritis	37	()	()	Liver/Gall Bladder Disorder	58	YES	NO	Are You Pregnant?
16	()	()	Rheumatoid Arthritis					Estimated Due Date _____			
				38	()	()	Cancer				
17	()	()	General Fatigue	39	()	()	Tumor	Other Health Problems			
18	()	()	Ringing in Ears	40	()	()	Asthma	59	()	()	_____
19	()	()	Visual Disturbances	41	()	()	Chronic Sinusitis	60	()	()	_____
20	()	()	Dizziness	42	()	()	Seasonal Allergies	61	()	()	_____

20. Primary Care Physician _____ 20b. Date of Last Medical Physical _____

21. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: _____

22. List all prescription and over-the-counter medications, nutritional/herbal supplements you are taking:

23. List all the surgical procedures you have had and times you have been hospitalized:

24. Detail any history of trauma to head, neck, or back (automobile accidents, sports injuries, work-related accidents, etc):

Patient Signature _____ Date _____

SYMMETRY CHIROPRACTIC & ACUPUNCTURE

24115 W. 103rd Street, Suite A ~ Naperville, IL 60564 ~ 630-983-1805

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

THIS NOTICE DESCRIBES HOW HEALTH RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

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: 1) Your personal health information, including 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. 2) Your health records as well as your billing records may be disclosed to another party, such as an insurance carrier (HMO, PPO, etc), or your employer (if they are responsible for payment). 3) Your name, address, phone number and your health records may be used to contact you regarding appointment reminders or provide information about alternatives to your present care. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. 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 the authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- 1.) If we are providing health care services to you based on the orders of another health care provider.
- 2.) If we provide health care services to you in an emergency.
- 3.) If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- 4.) If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.

We normally provide information about your health care 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. By signing below, I acknowledge that I have read the above information and give full disclosure of my information.

Patient's/Guardian Signature

Date

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____

Date: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) records 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, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient Signature: _____

Date: _____