Brookville Chiropractic Center
582 Upper Lewisburg-Salem Rd. Brookville, OH 45309
(937) 833-4200 (p) ~ (937) 833-3444 (f)

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____
Address: _____ Home Phone: _____
City: _____ Zip: _____ Cell Phone: _____
SS#: _____ Email: _____
Date of Birth: _____ Age: _____ Marital Status: ☐M ☐S ☐W ☐D # of Children: _____
Occupation: _____ Employer: _____
Address of Insured (if different than above): _____
Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ☐ Yes ☐ No
Ins. Company: _____ Policy Holders Employer: _____
ID#: _____ Ins. Phone #: _____
Name of Policy Holder: _____ Group #: _____
Policy Holder DOB: _____

Family Physician: _____ (Note: May we send your health information to this provider ☐ Y ☐ N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? ☐ Y ☐ N If so, Who & When? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? ☐ Y ☐ N Have you ever had any Hip or Knee Replacements ☐ Y ☐ N

Are or were you a smoker? ☐ Y ☐ N If yes, for how long? _____ When did you quit? _____

What medications or drugs are you taking? (Check those that apply):

☐ Pain Killers ☐ Insulin ☐ Cholesterol Meds ☐ Blood Pressure Meds

☐ Muscle Relaxers ☐ Birth Control ☐ Other: _____

Do you have a Family History of:

Mother's Side: Cancer____ Type: _____ Diabetes: Type 1____ Type 2____ Stroke ____ Cardiovascular____ Other_____

Father's Side: Cancer ____ Type: _____ Diabetes: Type 1____ Type 2____ Stroke ____ Cardiovascular____ Other_____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Brookville Chiropractic Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

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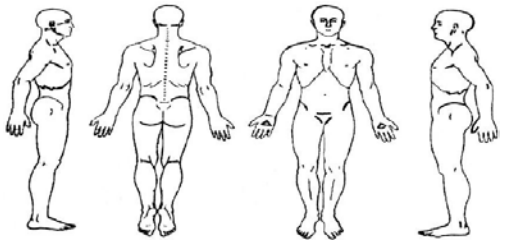
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity Minimal Severe	Frequency (% of week) Occasional Constant
a.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	☐0 ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100
b.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	☐0 ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100
c.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	☐0 ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100
d.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	☐0 ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100
e.	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	☐0 ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (select what applies)

☐ morning ☐ Increase during the day
☐ afternoon ☐ same all day
☐ night ☐ decrease during the day

3. Symptom (a.) is: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Numbness ☐ Tingling ☐ Pins & Needles

4. Symptom (b.) is: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Numbness ☐ Tingling ☐ Pins & Needles

5. When did your symptoms begin (onset date)? _____

6. How did your symptoms begin? _____ Is it due to _____ Work _____ Auto _____

7. Have you experienced these before? _____

8. Do your symptoms radiate? ☐ Yes ☐ No If yes, From _____ to _____

9. Has your condition? ☐ Improved ☐ Gotten Worse ☐ Stayed the same since it began

10. Circle the things that make your problems worse:

☐ Coughing ☐ Sneezing ☐ Bending ☐ Lying ☐ Walking ☐ Standing
☐ Sitting ☐ Movement ☐ Twisting ☐ Lifting ☐ Sleeping ☐ Driving

11. Is there anything you can do to relieve the problems? ☐ No ☐ Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ☐ No ☐ Yes How long ago? _____ By Whom? _____

13. What treatment did you receive? _____

14. Results of previous treatment? ☐ Good ☐ Poor Comments _____

15. Were you referred to our office by anyone? _____

16. Is this condition interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ☐ No ☐ Yes Neurological problems? ☐ No ☐ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date:

Brookville Chiropractic Center
582 Upper Lewisburg-Salem Rd. Brookville, OH
937-833-4200

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Brookville Chiropractic Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of 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. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

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

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date