

Tipp City Chiropractic Center
215 S. Garber Drive, Tipp City, OH 45371
(937) 667-7700 (p) ~ (937) 667-5189 (f)

Date: _____

Confidential Patient Information

Patients Name: _____	Chief Complaint: _____
Address: _____	Home Phone: _____
City: _____ Zip: _____	Cell Phone: _____
SS#: _____	Email: _____
Date of Birth: _____ Age: _____	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> 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?) <input type="checkbox"/> Yes <input type="checkbox"/> 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 **Tipp City 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: _____

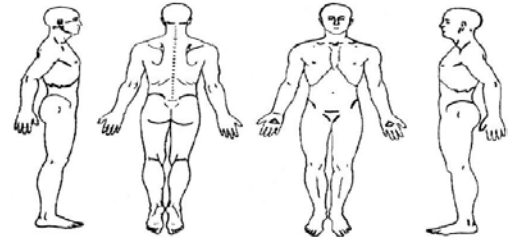
1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

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

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(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 Tipp City 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