CASE HISTORY

Name: ______ Age: ______ Date: ______ CELL CARRIER: ______
Address: ______ City: ______ State: ______ Zip: ______
Phone (Home): ______ Cell ______ E-mail: ______
Date of Birth: ______ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children: ______
Occupation: ______ Employer: ______ Telephone (Work): ______ Ext. ______
Insured's Name: ______ Phone: ______ Insured's Date of Birth: ______
Spouse's Name: ______ Spouse's Occupation: ______
Spouse's Employer: ______ Spouse's Telephone (Work): ______
Past Chiropractic Care: ❑ Yes ❑ No When? ______ Doctor's Name: ______
Results: ______ Referred by: ______
Insurance Company: ______ Telephone: ______
Social Security Number: ______ HISPANIC: ___ NON HISPANIC: ______
Spouse's Insurance Company: ______ RACE: ___ PRIMARY LANGUAGE: ______
EMERGENCY CONTACT NAME/NUMBER: ______ LANGUAGE PREFERENCE: ______
Chief Complaint: 1. ______ Duration-(How Long): ______ Previous Episodes: ______
List Current: 2. ______ Duration-(How Long): ______ Previous Episodes: ______
Problems: 3. ______ Duration-(How Long): ______ Previous Episodes: ______

Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other: ______
Has the accident been reported? ❑ No ❑ Yes ❑ To Employer ❑ Auto Carrier ❑ Other: ______
Are you now or have you ever been disabled? (Service or Work)? ❑ No ❑ Yes When? ______ Why? ______
Have you retained an attorney? ❑ No ❑ Yes Name & Address: ______

Please mark the intensity of your pain today.
1 - NO PAIN
10 - MOST INTENSE EVER FELT

Example ___Neck___
1 2 3 ④ 5 6 7 8 9 10

1 ______
1 2 3 4 5 6 7 8 9 10

2 ______
1 2 3 4 5 6 7 8 9 10

3 ______
1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness
P-Pain
A-Ache
ST-Stiffness

Left

Left

DOCTORS USE ONLY

______
______
______
______

HABITS

❑ Smoking Packs/Day: ______
❑ Drinking Alcohol: ______
❑ Caffeine Cups/Day: ______

EXERCISE

❑ None
❑ Light Activity
❑ Moderate Activity
❑ Active
❑ Very Active
❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑ ______
Father	❑	❑	❑	❑	❑ ______
Brother,# of ___	❑	❑	❑	❑	❑ ______
Sister,# of ___	❑	❑	❑	❑	❑ ______

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently

Never / Previously / Presently		GENERAL SYMPTOMS
❑ ❑ ❑	995.3	Allergy (What)____
❑ ❑ ❑	490	Bronchitis
❑ ❑ ❑	780.9	Chills
❑ ❑ ❑	780.39	Convulsions
❑ ❑ ❑	780.4	Dizziness
❑ ❑ ❑	780.2	Fainting
❑ ❑ ❑	780.79	Fatigue
❑ ❑ ❑	780.6	Fever
❑ ❑ ❑	784.0	Headache
❑ ❑ ❑	780.52	Loss of Sleep
❑ ❑ ❑	783	Loss of Weight
❑ ❑ ❑	799.2	Nervousness
❑ ❑ ❑	729.2	Neuralgia
❑ ❑ ❑	780.8	Sweats
❑ ❑ ❑	786.07	Wheezing
❑ ❑ ❑	311	Depression

Never / Previously / Presently		GASTRO-INTESTINAL
❑ ❑ ❑	787.3	Belching/Gas/Bloating
❑ ❑ ❑	789.0	Abdominal Pain
❑ ❑ ❑	564.0	Constipation
❑ ❑ ❑	787.91	Diarrhea
❑ ❑ ❑	783.6	Excessive Eating
❑ ❑ ❑	575.9	Gall Bladder Trouble
❑ ❑ ❑	455	Hemorrhoids (piles)
❑ ❑ ❑	782.4	Jaundice
❑ ❑ ❑	794.8	Liver Trouble
❑ ❑ ❑	787.02	Nausea
❑ ❑ ❑	536.9	Stomach Pain
❑ ❑ ❑	783.0	Poor Appetite
❑ ❑ ❑	536.8	Poor Digestion
❑ ❑ ❑	787.03	Vomiting
❑ ❑ ❑	578.0	Vomiting Blood
❑ ❑ ❑	783.5	Excessive Thirst
❑ ❑ ❑	536.8	Indigestion
❑ ❑ ❑	569.3	Rectal Bleeding

Never / Previously / Presently		EYE/EAR/NOISE/THROAT
❑ ❑ ❑	493.9	Asthma
❑ ❑ ❑	378.9	Crossed Eyes
❑ ❑ ❑	389.9	Deafness
❑ ❑ ❑	388.70	Earache
❑ ❑ ❑	388.60	Ear Discharge
❑ ❑ ❑	388.30	Ear Noises
❑ ❑ ❑	240.9	Enlarged Thyroid
❑ ❑ ❑	460	Frequent Colds
❑ ❑ ❑	477	Hay Fever
❑ ❑ ❑	784.49	Hoarseness
❑ ❑ ❑	478.1	Nasal Obstruction
❑ ❑ ❑	784.7	Nosebleeds
❑ ❑ ❑	379.91	Pain in Eyes
❑ ❑ ❑	368.9	Poor Vision
❑ ❑ ❑	461.9	Sinusitis
❑ ❑ ❑	462	Sore Throat
❑ ❑ ❑	463	Tonsillitis
❑ ❑ ❑	786.2	Persistent Cough
❑ ❑ ❑	787.2	Difficulty Swallowing
❑ ❑ ❑	523.8	Bleeding Gums

Never / Previously / Presently		RESPIRATORY
❑ ❑ ❑	786.50	Chest Pain
❑ ❑ ❑	786.2	Chronic Cough
❑ ❑ ❑	786.09	Difficulty Breathing
❑ ❑ ❑	786.3	Spitting Blood
❑ ❑ ❑	786.4	Spitting Phlegm

Never / Previously / Presently		GENITO-URINARY
❑ ❑ ❑	788.36	Bed Wetting
❑ ❑ ❑	599.7	Blood in Urine
❑ ❑ ❑	788.4	Frequent Urination
❑ ❑ ❑	788.3	Lack of Bladder Control
❑ ❑ ❑	590.9	Kidney Infection
❑ ❑ ❑	788.1	Painful Urination
❑ ❑ ❑	601.9	Prostate Trouble

Never / Previously / Presently		MUSCLES/JOINTS/BONES
❑ ❑ ❑	724.5	Backache
❑ ❑ ❑	719.7	Foot Trouble
❑ ❑ ❑	550	Hernia
❑ ❑ ❑	719.1	Pain Between Shoulders
❑ ❑ ❑	724.6	Painful Tail Bone
❑ ❑ ❑	723.9	Stiff Neck
❑ ❑ ❑	781.9	Spinal Curvature
❑ ❑ ❑	719.0	Swollen Joints
❑ ❑ ❑	781.0	Tremors/Twitching
❑ ❑ ❑	782	Arm Trouble

Never / Previously / Presently		CARDIO-VASCULAR
❑ ❑ ❑	401.9	High Blood Pressure
❑ ❑ ❑	458.9	Low Blood Pressure
❑ ❑ ❑	786.51	Pain Over Heart
❑ ❑ ❑	785.9	Poor Circulation
❑ ❑ ❑	438	Previous Heart Trouble
❑ ❑ ❑	785.0	Rapid Heart
❑ ❑ ❑	427.89	Slow Heart
❑ ❑ ❑	436	Strokes
❑ ❑ ❑	719.7	Swelling Ankles
❑ ❑ ❑	454	Varicose Veins

Never / Previously / Presently		SKIN OR ALLERGIES
❑ ❑ ❑	680.9	Boils
❑ ❑ ❑	924.9	Bruising Easily
❑ ❑ ❑	701.1	Dryness
❑ ❑ ❑	691.8	Eczema
❑ ❑ ❑	708.9	Hives or Allergy
❑ ❑ ❑	698.9	Itching
❑ ❑ ❑	782.0	Sensitive Skin
❑ ❑ ❑	782.1	Skin Eruptions

Never / Previously / Presently		FOR WOMEN ONLY
❑ ❑ ❑	625.3	Cramps or Backaches
❑ ❑ ❑	626.2	Excessive Flow
❑ ❑ ❑	627.2	Hot Flashes
❑ ❑ ❑	626.4	Irregular Cycle
❑ ❑ ❑	634.9	Miscarriage
❑ ❑ ❑	625.3	Painful Periods
❑ ❑ ❑	623.5	Vaginal Discharge
❑ ❑ ❑	611.79	Lump in Breast
❑ Yes ❑ No		Pregnant at this time?
❑ Yes ❑ No		Have you had a mammogram?
______		Last Pap Date
______		By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
______	Vaccinations	______	Tubes in Ears	______	Sinus
______	Tonsillectomy	______	Appendectomy	______	Hernia
______	Gall Bladder	______	Female Organs	______	Thyroid
______	Back Operation	______	Rectal Surgery	______	Stomach
______	Other: ______	______	Other: ______	______	Other: ______

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car: ______ ❑ Recreation: ______

❑ Sports ______ ❑ School: ______ ❑ Other: ______

List any broken bones (fractures) or dislocations: ______

Ever on crutches? ❑ Yes ❑ No Why? ______

Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No

Have you ever had a lapse of memory? ❑ Yes ❑ No

Have you ever had X-rays taken? ❑ Yes ❑ No When? ______ By Whom? ______

For what ailments were these X-rays made? ______

Do you suffer from any condition other than that for which you are now consulting us? ______

Are you presently taking any medication - prescription or over-the -counter? ❑ Yes ❑ No What drugs? ______

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 form the in insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature: X ______ Date: ______

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

DATE ______________________ SIGNATURE ______________________

©

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed, directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of TX.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization for Assignment will be in continual effect until revoked by both parties.

________________ Date　　　　________________________ Patient/Insured Signature

---

RECORDS RELEASE

To ____________________, I hereby authorize you to release to ________________________ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period from ________ to __________.

________________ Date　　　　________________________ Patient/Insured Signature

________________ Date　　　　________________________ Staff Signature

---

RELEASE FROM CARE

I, ____________________ hereby understand that Dr. __________________ is releasing me from care, for my accident dated ______________, and that I have reached ☐ a pre-accident status or ☐ maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

____________________ Patient Signature　　________________ Date　　____________________ Staff Signature

©

MISSION CHIROPRACTIC & INJURY CLINIC, P.A.
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, ____________________________ [Name of Individual] consent to MISSION CHIROPRACTIC & INJURY CLINIC, P.A.'s ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

Copyright © 2002 Brown Rudnick eSolutions, LLC. All Rights Reserved

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________, [patient's name] acknowledge that I have received, reviewed, understand and agree to the the Notice of Privacy Practices of MISSION CHIROPRACTIC & INJURY CLINIC, P.A., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

____________________ Date

____________________ Signature

____________________ Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of ____________________ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

☐ Personally ☐Mail ☐Phone Follow Up

☐ Other: ____________________

____________________ Date

____________________ Signature

____________________ Print Name of Physician

MISSION CHIROPRACTIC & INJURY

Date: ______ Name: ______________________________

1. Have you had any new symptoms, injuries, or complaints since your last treatment: YES/NO
   If yes please explain: ______________________________
2. Where do you have pain? ______________________________
3. What makes the pain worse? ______________________________
4. What makes the pain better? ______________________________
5. What time of day is the pain worse? A.M, Midday, P.M. (circle)
6. What time of day is the pain better? A.M, Midday, P.M. (circle)

Mark areas where you have symptoms.

Analog Pain Scale- Rate how you feel BEFORE your treatment today.

(Circle the number that best describes) 0 1 2 3 4 5 6 7 8 9 10

No Pain — Low Pain — Moderate Pain — Intense Pain — Excruciating Pain

PATIENT SIGNATURE: ________________________

FOR OFFICE USE ONLY

C T L E _____ IF/Russian ______________________________
to: __relieve pain __ reduce edema __ increase blood flow __ reduce spasms

C T L E _____ Ultrasound ______________________________
to: __relieve pain __ reduce edema __ increase blood flow __ relieve spasms
__ reduce nerve root irritation

C T L E _____ Manual/ MechanicalTraction ______________________________
to: __ break up fixations __ stretches fibrotic tissue and adhesions
__ relieve spasms __ increase joint mobility __ restore elasticity and resiliency
__ restore normal spine curve __ strengthen myoligmentous attachments

C T L E _____ Ice/Heat ______________________________
to: __relieve pain __ reduce edema __ increase blood flow __ reduce spasms
__ relieve muscle tightness __ relax tissue __ controls hemorrhages __ elastic tissue
__ increase vascular and lymphatic circulation __ decrease metabolic rate

C T L E _____ Therapeutic exercises (One on One) or (Group) ______________
to: __ develop strength and endurance __ increase mobilization

Plan: chiropractic Adjustment Cervical 1 2 3 4 5 6 7 Thoracic 1 2 3 4 5 6 7 8 9 10 11 12 Lumbar 1 2 3 4 5 PI, AS, EX, IN

Occiput
C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
Pelvis
Sacrum

S. See "S" above.

O. See "O" above

A.

P. See "P" above

Range of Motion

	Cervical	Thoracolumbar
Pre		
Flexion	_____	_____
Extension	_____	_____
LLF	_____	_____
RLF	_____	_____
LR	_____	_____
RR	_____	_____
Post		
Flexion	_____	_____
Extension	_____	_____
LLF	_____	_____
RLF	_____	_____
LR	_____	_____
RR	_____	_____

Examiner: ______________________________