INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** Single / Married / Other

Social Security #: _____ **Date of Birth:** _____

Student Status: Full Student / Part Student / Non-Student **Employed:** Y / N

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

***Referred By:** (*Name):* _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay *(Cash)* ☐ Personal Injury/Auto ☐ Other *(please explain)*: _____

PRIMARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: _____ **Gender:** M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date of Birth:** _____

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - *(Relationship)* _____

Other than Self:

Name: *(First MI Last)* _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

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

Patient No: _____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Describe any Secondary Complaints: _____

Describe WHEN and HOW this began: _____

_____

_____

Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes *(Describe)* _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both *Leg* - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand-Fingers R / L / Both *Other Area:* _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? *(Describe)* _____

For this CURRENT condition, have you:

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____
- **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

HEALTH HISTORY – *(PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)*

Medications and Supplements:

Allergies to Medications: *NONE*

Name	Reaction

Current Medications & Supplements: *NONE*

Name	Dosage	Frequency	Method

Past Health History: *(Please list any past...)*

Number of Falls in the last 24 months: _____ **Injuries?** Y or N

Surgeries: *NONE*

Date	Area of the Body	Reason

Major Injuries / Traumas / Hospitalizations: *NONE*

Date	Describe

Family Health History: *N/A*

List *relevant* major health problems of First degree relatives:

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

Social and Occupational History:

Smoking/Tobacco Use: Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

Education: High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

Patient No: _____

Are you *currently* experiencing any of these symptoms? *(Check all the apply)*
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems _____
- ☐ Leg Problems _____
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones_____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: _____
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: _____
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____
- ☐ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: _____
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Women Only:

Are you pregnant?
- ☐ **Yes -** ***Due Date*** ___/___/___
- ☐ **No -** ***Last Menstrual Period*** ___/___/___
- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: _____
- ☐ *None in this Category*

Pregnancies:

Date	Outcome

Comments: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

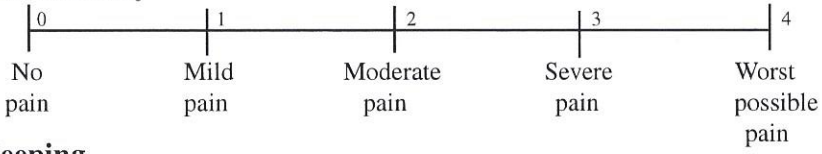
Patient No: _____

Functional Rating Index

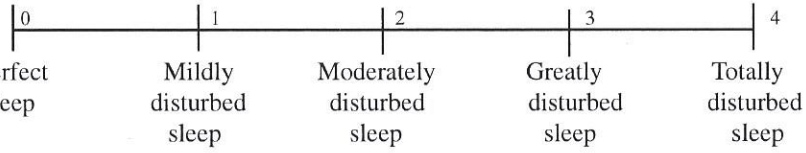
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

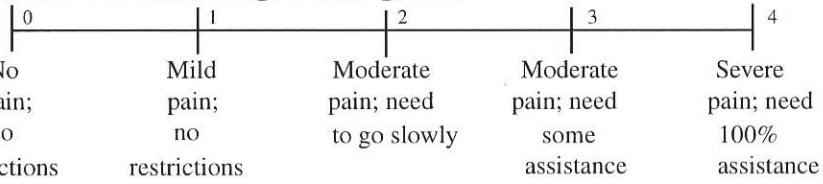
1. Pain Intensity



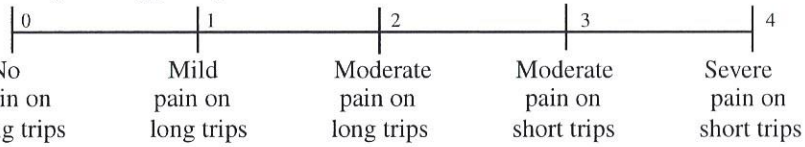
2. Sleeping



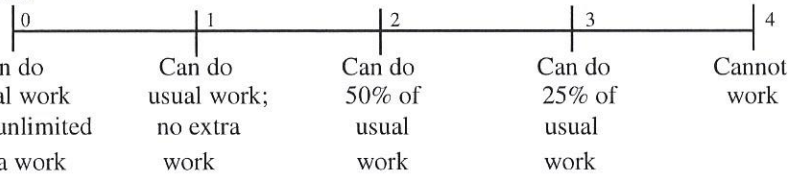
3. Personal Care (washing, dressing, etc.)



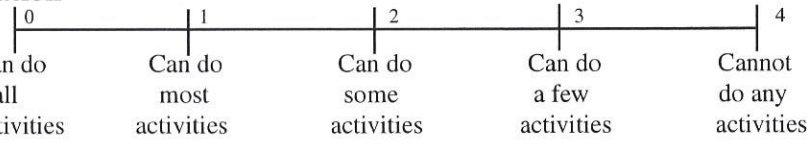
4. Travel (driving, etc.)



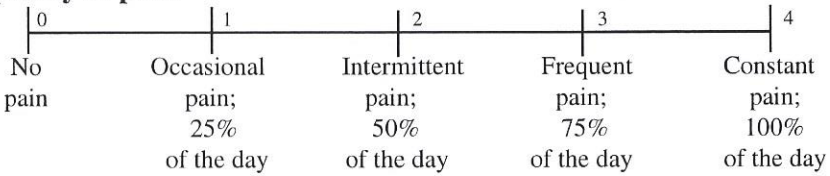
5. Work



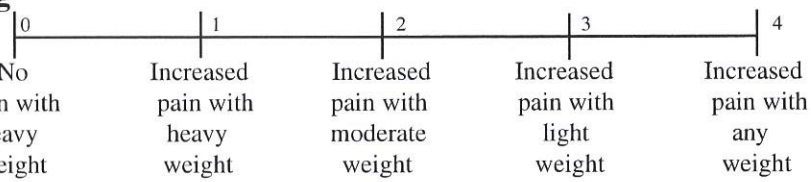
6. Recreation



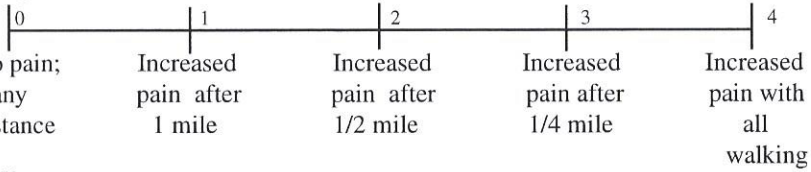
7. Frequency of pain



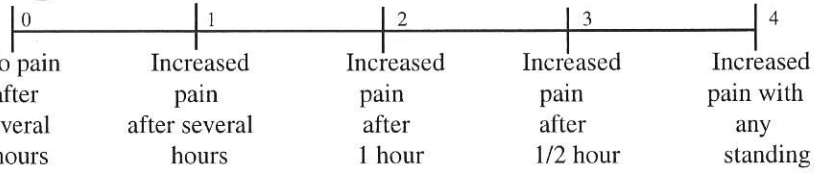
8. Lifting



9. Walking



10. Standing



Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

BACK & NECK CARE CENTER OF BEDFORD
2803 Central Drive Bedford, TX 76021
(817) 283-6100

Patient Name:
Patient D.O.B.:
Patient Number:

Informed Consent for Chiropractic Services

I have been informed of the following:

1. That the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies" may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. The listed possible consequences and possible complications have been explained to me by the chiropractor;
4. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
5. I have been afforded ample opportunity for questions and answers; and
6. The condition, possible benefits, risks of the treatment procedures, options, and financial obligations have been explained to me by the chiropractor.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____

Witness Signature:_____Date:_____

BACK & NECK CARE CENTER OF BEDFORD
2803 Central Drive Bedford, TX 76021
(817) 283-6100

Patient Name: _____ D.O.B.: _____ Date: _____

Radiology Consent

I have been explained the recommended radiology procedures, the potential risks and options. I understand the clinical necessity of having x-rays taken at this time and give my consent/permission for this procedure. In so doing I release the Doctor from responsibility, known and unknown, for potential damage arising from this procedure.

Additionally if Female

Patient X-ray Pregnancy Verification Form

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I again understand the clinical necessity of having x-rays taken at this time and give my consent/permission for this procedure. At the present time (please check one):

_____ I am sure that I am not pregnant.

_____ It is possible that I could be pregnant.

_____ I am pregnant.

_____
Patient Signature

_____ _____
Witness Printed Name Witness Signature

BACK & NECK CARE CENTER OF BEDFORD

2803 Central Dr. Bedford, TX 76021
Dr. Richard Chatfield

Health Insurance Portability & Accountability Act (HIPPA) Consent Form

THIS NOTICE DESCRIBES HOW 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 insurance carriers (HMO, PPO, etc.), or your employer (if they are responsible for payment). 3) Your name, address, phone number, email and your health records may be used to contact you regarding appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about your treatment alternatives or other health related information. A message may be left on your voicemail or answering machine. 4) Your name may be listed on our referral board of referring patients. 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 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:

- **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 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 or e-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. If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours. Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Richard Chatfield DC, Chiropractor to save these electronically for me and not print them out after each visit. I understand that, upon request that these reports are available to be printed or emailed to me for review.

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 my payment. I also understand that if I suspend or terminate treatment my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's/Guardian Signature_____**Date**_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic treatment or any clinic services that he deems necessary in my case; and I further authorize him 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 the patient or to a family member or employer of the patient for all or part of the clinic's charge including, but not limited to; hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or patient's employer.

Patient's/Guardian Signature_____**Date**_____

ASSIGNMENT OF BENEFITS

Patient: _____

Claim # _____ **Insurance Company:** _____

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and consideration of treatment rendered or to be rendered assigns to Richard Chatfield DC all benefits payable under the terms of my/our policy benefits.

Release of Information: You are authorized to release information concerning my condition and/or treatment to my insurance company, attorney or insurance adjuster, for the purpose of processing my claim for benefits and payment of services rendered to me.

Irrevocable Assignment of Rights: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, and other legally compensable amounts owned by and insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statue. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. **If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.** Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Richard Chatfield DC, Chiropractor to save these electronically for me and not print them out after each visit. I understand that, upon request that these reports are available to be printed or emailed to me for review.

Demand for Payment: To any insurance company providing benefits of any kind to me/us for treatment rendered by Richard Chatfield DC, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, collection percentage penalties, court costs, and interest from judgment, upon violation.

Third Party Liability: If my injuries are the result of negligence from a third party, then instruct the liability rendered, payable directly to Richard Chatfield DC, if the liability carrier will not cut a separate check to Richard Chatfield DC, I am giving the liability carrier permission to enter Richard Chatfield DC name on the draft that I am to receive to my medical expenses.

Statute of Limitations: I waive my rights to claim any statue of limitations regarding claims for services rendered or to be rendered by Richard Chatfield DC. In addition to reasonable costs of collection, including attorney fees and court costs if incurred.

Limited Power of Attorney: I hereby grant Richard Chatfield DC the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for services rendered by Richard Chatfield DC. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my account.

Termination of Care Wavier: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my doctor, he/she has the full and complete right to terminate responsibility for my care and relinquish and disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, or if I/we choose to see another doctor, I will notify Richard Chatfield DC immediately.

A photocopy of this instrument shall serve as an original.

_____ _____

Signature of patient/Responsible Party ***Date***