St. Henry Chiropractic, LLC Case History

Name_____ Sex M F Date of Birth_____Age_____

Address_____City_____State_____Zip_____

H. Phone_____ Cell Phone_____

E-mail _____ @ _____ May we contact you by e-mail? Yes No

Occupation_____ Employer_____W. Phone_____

Marital Status: S M W D Spouse's Name: _____

In Case of Emergency, Contact: _____ Phone _____

Referred by_____

Have you ever received Chiropractic Care? Yes No If yes, who? Dr._____ when? _____

Who is your medical doctor? _____ last seen when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Due to: Injury work injury auto accident gradual onset other_____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

Does this complaint/pain radiate or travel (shoot) to any areas of your body? No Yes Where? _____

Do you have any numbness or tingling in your body? No Yes Where? _____

How frequent is complaint present, and how long does it last? _____

Does anything make the complaint worse? _____

Does anything make the complaint better? _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for <u>this</u> complaint: _____

_____

3. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:

_____

_____

_____

C. Allergies _____

D. Medications & Supplements:

_____

_____

_____

E. Surgeries:

Date or Year	Type of Surgery
_____	_____
_____	_____
_____	_____

Any chance you could be pregnant now? No Yes

What was the date of the beginning of your last menstrual period? _____

3. Social and Occupational History:

A. Job description: _____

B. Hours of sleep: _____| **Tobacco use:** Smokes: Daily Occasional Former Never

C. Alcohol Consumption: _____| (**cigarettes per day):** _____

D. Coffee/Tea/Soft Drinks (cups per day): _____

E. Exercise (describe): _____

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 of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I hereby accept full responsibility for payment of services rendered me, and for charges not covered by insurance.

Patient or Guardian Signature _____ Date _____

St. Henry Chiropractic, LLC
570 E. Kremer Hoying Rd. Suite H St. Henry, OH 45883 (419) 678-4873

Patient Name: _____ Date: _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you.

Please read the below and if you have any questions, please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, 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 problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient at **St. Henry Chiropractic, LLC**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Authorization for Release of Records:

I hereby request the release of any and all records, including x-rays, MRIs, and CTs.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

If we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ___

May we leave messages regarding your personal healthcare information on any answering device, i.e., home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

EHR Certification - Patient Information

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: (To be entered in EZnotes through "Edit Patient Info")

Name: (Print clearly) _____ Today's Date: _____

Date of Birth: _____

Ethnicity: (Please circle)

Hispanic or Latino	Not Hispanic or Latino

Race: (Please circle all that apply)

White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other

If there is an emergency, in which language would you like to receive the message?

_____

What is your preferred method of contact? _____

Phone Number: _____ Home Work Cell

Phone Call: ☐ Text: ☐ E-Mail: ☐

If email was not your preferred method, please give your email address here:

_____

Mailing Address: _____

_____

_____

For confidential correspondence, please create a Secret Question i.e.: What was my first pet's name?

Secret Question: _____

Secret Answer: _____