Chiropractic Case History/Patient Information

Pt# ____

Diane Stewart DC

Date _____

Name:_____ DOB:_____ Age:_____ Gender ◉ ◉

Address:_____ City:_____ State:____ Zip:_____

Occupation:InIn _____ SS#:_____ Primary Care Physician:_____

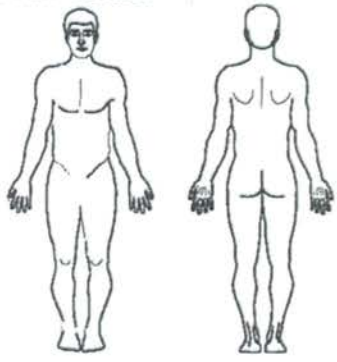
Preferred Method of Communication ☐ Email ☐ Mail ☐ Cell #_____ **Home #**_____

Work#_____ **Email:**_____ **Preferred Language :**_____

Would you like to be on our email list ☐ Ye ☐ No How did you hear about us?_____

Marital Status: S M W D Partner Children?_____ Emergency Contact_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

Current complaint (how you feel today):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Unbearable Pain

How often are your symptoms present?

(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unable to carry on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

Initial Health Status:

Pt#_____ Date_____

Patient Name_____

What do you think is wrong? _____

When did this problem begin and how did it happen?_____

_____

Prior Chiropractic Treatment? ☐Y ☐N Results?_____

Is this a: ☐New Condition ☐Recurrence (if yes, when was the first time this occurred?_____

Did your problem begin: ☐Suddenly ☐Gradually Is it getting worse? ☐Y ☐N ☐Same ☐Better

How long does it last? ☐All Day ☐Hours ☐Minutes ☐Night only ☐Constant ☐Only with certain movements

Describe the pain: ☐Sharp ☐Stabbing ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning

Other_____

Does anything make it better?_____

What have you tried that has not helped?_____

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Walking

☐Getting up/down ☐Other _____

What does your condition prevent you from doing or enjoying?_ _____

_____

Is there another condition or symptom related to your major problem or any other health problems you would like evaluated? _____

_____

Please list the changes you would like to occur _____

_____

Rate your stress level from 1-10 (10 being very stressful)____ Please explain _____

Rate your energy level from 1-100 (100 being the best)_____

Food Allergies? ☐Y ☐N Please List _____

Check if you use: ☐Supplements ☐Arch Supports ☐Heel lifts, ☐Mouth guard ☐Joint Braces

Do you exercise ☐Y ☐N Describe:_____

How much water do you drink/day? _____

We would like to know what you would be willing to do to get well! Please check the following if you are:

☐willing to change your diet? ☐willing to take supplements?

☐willing to do laboratory testing? ☐willing to exercise?

☐Willing to read books that we may suggest? ☐Willing to change your lifestyle?

☐Willing to commit time to your wellness? ☐1 month ☐3 months? ☐6 months?

Are you pregnant? ☐Y ☐N Nursing? Planning to become pregnant?

Smoking Status (Circle one):
Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked How much? _____

24 Hour Cancellation Notice is

AUTHORIZATION and RELEASE: I authorize payment of insurance benefits directly to Dr. Diane Stewart. I authorize Dr. Stewart to release all information necessary to communicate with personal physicians and other healthcare providers/payors and to secure the payment of benefits. If I suspend or terminate my schedule of care as determined by Dr. Stewart, any fees for services rendered will be immediately due and payable.

The patient understands and agrees to allow this Chiropractic Office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. We want you to know how your PHI is going to be used in this office and your rights concerning those records. A more detailed account of our policies and procedures concerning the privacy of your PHI in the HIPAA Notice that is available for review at our office. If there is anyone you do not want to receive your medical records, please inform our office.

*Patient Signature*_____ *Date*2_____

Initial Health Status: cont.:

Pt#_____ Date_____

Patient Name_____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications) ***If more than 3 medications, please list on separate page**

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **Yes** ☐ **No** **I want a copy of my treatment summary emailed to me after every visit.**

Patient Signature: _____ Date:_____

Height: InIn_____ Weight:_____ Temp: _____

Blood Pressure:_____ /_____ Heart Rate: _____

Lyte² Touch Chiropractic and Wellness 24 Hour Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. We want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours. As of January 1 2018 there will be a fee of **$30.00** assessed if we do not receive a call to cancel an appointment. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all our patients.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for *Lyte² Touch Chiropractic and Wellness* as described above.
Thank you for your understanding and cooperation.

☐ **I have read and understand the Cancellation Policy**

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☐ **I have read and understand the Authorization and Release**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Diane Stewart.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

☐ *I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.*

*Patient Signature*_____ *Date* 2