Introduction Patient Case History

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* ______________________________ **Preferred Name:** ______________

Address: ______________________ **City:** ____________ **State:** _______ **Zip:** ____________

Date of Birth: ___________ **Gender:** ☐ Male ☐ Female **Social Security #:**_____________

Home: ______________ **Mobile:** ______________ **Work:** ______________

Email: ______________________________

Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone - *Home, Mobile, or Work* ☐ Other: ___________

***Referred By:** *(Name)* ______________________

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: ___________

Race & Ethnicity: *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _______________
- ☐ Decline

EMERGENCY CONTACT INFORMATION

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

Home: ______________ **Mobile:** ______________ **Doctor's Phone:** ______________________

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: ______________

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: ___________

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: ______________________ *ID#:* ______________

Secondary: ______________________ *ID#:* ______________

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: ______________________________

Address: ______________________________

Phone: ______________ *Email:* ______________________

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

Account No: ___________

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: ____________________________________

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____

Secondary Complaints: ________________________________

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When did it start? ____/____/_____ **What happened?** ____________________________________

____

Which daily activities are being affected by this condition? ____________________________________

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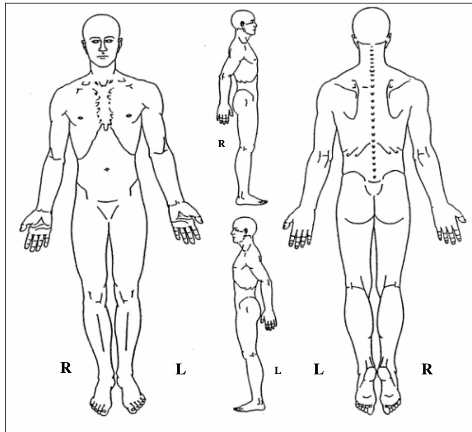
MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm
T__ Tender
H__ Hypoesthesia

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: __________________

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _______________
- ☐ Other: ________________________

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: ___________________________

Previous Treatment:

- ☐ None
- ☐ Chiropractor ______________________
- ☐ Medical Doctor ____________________
- ☐ Physical Therapy __________________
- ☐ ER/Urgent Care ___________________
- ☐ Orthopedic _______________________
- ☐ Other: __________________________

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays __________________________
- ☐ MRI ____________________________
- ☐ CT _____________________________
- ☐ Other: __________________________

Women:** ***Are you pregnant?

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

Present Illness Comments:

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Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)* ________________________

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Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*____________________________

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PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:
- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) ________
- ☐ Blood Clots
- ☐ Cancer (*Type*) ____________________
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _________________________

____

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Injuries:
- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _________________________

Hospitalizations: *(Non-surgical with Date)*

____

____

Surgeries: *(If yes, provide type & surgery date)*
- ☐ Cancer _________________________
- ☐ Orthopedic
  - Shoulder – R / L ____________
  - Elbow/Forearm – R / L ____________
  - Wrist/Hand – R / L ____________
  - Hip – R / L ____________
  - Knee – R / L ____________
  - Ankle/Foot – R / L ____________
- ☐ Spinal Surgery
  - Neck: ________________________
  - Back: ________________________
- ☐ Other: _________________________

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Medical History Comments:

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FAMILY HISTORY *(Please mark **X** to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

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SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:________________

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.
☐ Post Grad. ☐ Other: ________________________________

Employed: ☐ No ☐ Yes (*Occupation*) ______________________

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* ___________
☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:
☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:
☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:
☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: ________________________________

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REVIEW OF SYSTEMS

Many of the following conditions respond to chiropractic treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: ______________________
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones_________________
- ☐ Other: ______________________
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: ______________________
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ______________________
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: ______________________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ______________________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: ______________________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: _________________
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: ______________________
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: ______________________
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: ______________________
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: ______________________
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: ______________________
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: ______________________
- ☐ *None in this Category*

Review of Systems Comments:

____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date______________________

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Informed Consent and Permission Form

When you give your permission to have chiropractic spinal adjustments and physical medicine modalities performed you or your guardian should understand the most common risks and hazards of these procedures. These are all rather infrequent but may occur:

1. Post treatment discomfort, or soreness or stiffness, which may persist 12 to 24 hours after treatment.

2. Transient lightheadedness or dizziness following chiropractic adjustments of the neck. Please alert Dr. Snyder should this reaction occur.

3. Aggravation of acute intervertebral disc bulge or herniation. Please be advised that Dr. Snyder will make reasonable efforts to determine the possibility of an underlying disc problem and modify your treatment recommendations accordingly.

4. Spontaneous vertebral body or rib fracture in an osteoporotic patient. Please be advised that Dr. Snyder will make every reasonable effort to diagnose this preexisting condition and modify your treatment recommendations accordingly.

5. Acute onset of muscle spasms alongside the spine in the area being treated or in an adjacent area. These muscle spasm reactions are commonly present, even before treatment, in the acute patient and every effort will be made to reduce them prior to spinal adjustments.

I understand that no guarantee had been made and that the procedures may not cure my condition.

Authorization To Release Information: Assignment of Benefits

I hereby authorize assignee to release information to secure payment for my care at this facility, as well grant permission to request records from other agencies pertinent to my health care. I hereby assign payment of my benefits, including major medical benefits to which I am entitled, private insurance or any other health plan to:

Dr. Justin G. Snyder D.C.
4146 S. Harvard Ave. Suite F-5
Tulsa, OK 74135

A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by insurance. If the account is placed in collections, additional charges equal to the cost of collections including agency and attorney fees and court cost incurred and permitted by law governing these transactions will be added to the amount due. These services and this agreement were entered into agreement, in the City of Tulsa.

Date__________________________ ____

Signature

____

Printed Name

DOCTOR'S STATEMENT: The patient (guardian) and I have discussed the procedures to be preformed. To the best of my knowledge, the patient (guardian) understands the procedures and consents to it.

Dr. Justin G. Snyder D.C.

Snyder Chiropractic
4146 S. Harvard Ave. Suite F-5
Tulsa, OK 74135

Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice of the privacy rights has also been provided to you.

Snyder Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of your care that you receive.

Snyder Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Snyder Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Snyder Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, government function in order to comply with workers compensation laws and regulations. A right to request restriction, report and retain a copy of your health records, request communication authorization and request any accounting of your health records.

You may complain to Dr. Snyder and the Department of Health and Human services if you believe your privacy rights have been violated. You will not be retaliated against for filling a complaint.

Dr. Snyder must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restrictions on how your information is used and disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any other questions or complaints please contact Dr. Snyder D.C. at 918-749-7772.

Patient Signature____________________________________Date____________________________