Chiropractic Case History/Patient Information

Date:__________________ Patient #___________ Doctor:__Laura Murphy, DC, DICCP___

Name: __________________________________ Social Security # (Medicare & VA only): ____________________

Address:_____________________________________City:___________________ State:______ Zip:___________

E-mail address:_____________________________ Home Phone: ________________Fax #__________________

Cell Phone:__________________ Age:_______ Birth Date:___________ Marital: M S W D

Occupation:_________________________ Employer:____

Employer's Address:___________________________________ Office Phone:______________________________

Spouse:___________________ Occupation:________________ Employer:___________________________________

How many children?____________Names and Ages of Children:____

____

Name of Nearest Relative:________________________ Address:______________________Phone:___________

How were you referred to our office?____

Family Medical Doctor:____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?___________

Please check any and all insurance coverage that may be applicable in this case**:**

- ☐ Major Medical
- ☐ Worker's Compensation
- ☐ Medicaid
- ☐ Medicare
- ☐ Auto Accident
- ☐ Medical Savings Account & Flex Plans
- ☐ Other

Name of Primary Insurance Company:____
Name of Secondary Insurance Company (if any):____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

____

____

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:____________________________________ Date:________________

PATIENT NAME ____

DATE ____________________ Doctor_Laura Murphy, DC, DICCP__

HISTORY OF PAST & PRESENT ILLNESS:

Date of last physical examination:_______________________________

Do you have a history of stroke or hypertension?____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): ____

____

____

Please list all broken bones and age & how and when you broke it: _____________________________________

____

____

Have you been treated for any health condition by a physician in the last year? _______Yes _______ No

If yes, describe:____

What medications or drugs (prescription and over the counter) are you taking?_____________________________

____

List all supplements you're taking: ____

____

____

Do you have any allergies to any medications? _______Yes _______ No If yes, describe: ________________

____

Do you have any allergies of any kind? _______Yes _______ No

If yes, describe:____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe ______________________________

Do you smoke: _______ Yes _______ No If yes, how many/day? __________________________________

How many alcoholic beverages do you drink/week? ____

How much water do you drink/day? __________ Is it filtered? ________

How many and what kind of caffeinated beverages do you regularly consume? ___________________________

Number of servings of vegetables/day: ______________ Number of servings of fruit/day: ___________________

How many times do you eat out/week? ______________ Number of servings of fish/week: __________________

3 Healthiest food you eat each week: ____

3 Unhealthiest food you eat each week: ____

PATIENT NAME ____

DATE ____________________ Doctor___Laura Murphy, DC, DICCP____

HISTORY OF PRESENT ILLNESS

1. What is your major symptom? ____
2. Date symptom appeared or accident happened: ____
3. Is this due to: Auto ____ Work ____ Other ____
4. What does this prevent you from doing or enjoying?____
5. If this is a recurrence, when was the first time you noticed this problem?____________________________
   How did it originally occur?____
6. Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? ____
7. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _________ Few Hours ___________ Minutes ______________
8. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: ____
9. Are there other unrelated health problems? Yes _____ No _____. If yes, describe __________
   ____
10. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
    Burning _____ Stabbing _____ Other ____
11. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe ______________
    __________________________. If no, what have you tried to do that has not helped? ______________
    ____
12. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____
    Lifting _____ Twisting _____ Other____
13. Days missed from work/school/practice: ____
    ____
14. Remarks: ____
    ____

NO SYMPTOMS EXTREME SYMPTOMS

Please place an “X” on the line above to indicate level of problem.

WOMEN only:
Are you Pregnant? Yes ____ No ____ Unsure ____ Date of last menstrual period:___________________

I hereby acknowledge that Dr. Laura Murphy of Lifetime Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Patient Signature ____ Date _____________

PATIENT NAME ____

DATE ____________________ Doctor_Laura Murphy, DC, DICCP__

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

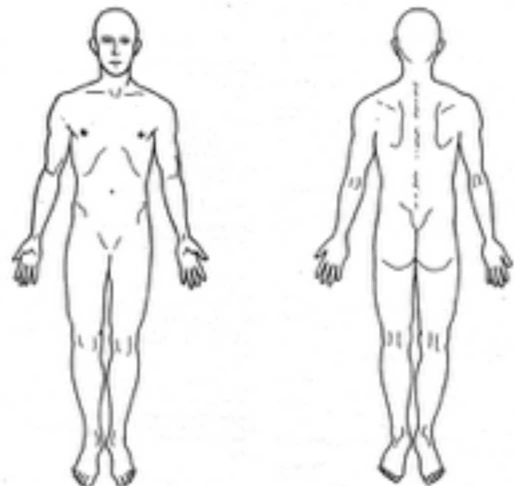
Headaches______ Frequency	_______	Loss of Balance	_______
Neck Pain	_______	Fainting	_______
Stiff Neck	_______	Loss of Smell	_______
Sleeping Problems	_______	Loss of Taste	_______
Back Pain	_______	Unusual Bowel Patterns	_______
Nervousness	_______	Feet Cold	_______
Tension	_______	Hands Cold	_______
Irritability	_______	Arthritis	_______
Chest Pains/Tightness	_______	Muscle Spasms	_______
Dizziness	_______	Frequent Colds	_______
Shoulder/Neck/Arm Pain	_______	Fever	_______
Numbness in Fingers	_______	Sinus Problems	_______
Numbness in Toes	_______	Diabetes	_______
High Blood Pressure	_______	Heartburn/Reflux	_______
Difficulty Urinating	_______	Joint Pain/Swelling	_______
Weakness in Extremities	_______	Menstrual Difficulties	_______
Breathing Problems	_______	Weight Loss/Gain	_______
Fatigue	_______	Depression	_______
Lights Bother Eyes	_______	Loss of Memory	_______
Ears Ring	_______	Buzzing in Ears	_______
Broken Bones/Fractures	_______	Circulation Problems	_______
Rheumatoid Arthritis	_______	Seizures/Epilepsy	_______
Excessive Bleeding	_______	Low Blood Pressure	_______
Osteoarthritis	_______	Osteoporosis	_______
Pacemaker	_______	Heart Disease	_______
Stroke	_______	Cancer	_______
Ruptures	_______	Coughing Blood	_______
Eating Disorder	_______	Alcoholism	_______
Drug Addiction	_______	HIV Positive	_______
Gall Bladder Problems	_______	Autoimmune Disease	_______
Ulcers	_______	Thyroid Disorder	_______
Heart Palpitations	_______	Lyme Disease	_______

SOCIAL HISTORY
Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

__________	Vigorous Exercise	__________	Family Pressures
__________	Moderate Exercise	__________	Financial Pressures
__________	Alcohol Use	__________	Other Mental Stresses
__________	Drug Use	__________	Other (specify)______
__________	Tobacco Use		
__________	High Stress Activity		

PLEASE USE THE DIAGRAM ON THE RIGHT TO TELL US WHERE YOU HURT.

Ache > > > > >
Numbness = = = = = =
Pins & Needles o o o o
Burning x x x x
Stabbing / / / / /
Throbbing ~ ~ ~ ~ ~ ~



PATIENT NAME ____

DATE ____________________ Doctor_Laura Murphy, DC, DICCP__

FAMILY HISTORY
Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: ___________________

____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient ____ Date: __________________

Signature of Patient/Legal Guardian ____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

______________________________	______________________________	______________
Name of Patient	Signature of Patient	Date

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_________________________________ Date_______________

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of _______________________, 20___

By____________________________________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____________________________________
Signature of Parent/Guardian (circle one)

Please review options below and sign the one(s) you want to give us permission to contact you other than phone.

I, _____________________________, give Lifetime Chiropractic permission to email me

at _____________________________. I understand that unless both email addresses are secure, there is a possibility that it could be seen by other people.

I, _____________________________, give Lifetime Chiropractic permission to text me

at_____________________________. I understand that text messages are not secure and there is a possibility that they can be seen by other people.

Patient or Parent/Guardian Signature: ____

Date: ___________________