Hill Country Chiropractic

401 Junction HWY - Kerrville, TX 78028 - 830.896.4108

Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____ Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office-Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

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?_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__Ulcers

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): _____

_____

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

If yes, describe:_____

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What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? π Yes/Describe_____ π No

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

FAMILY HISTORY:

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	

Other _____

Please check any and all insurance coverage that may be applicable in this case**:**
π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π 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 payers 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

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CONSENT TO TREAT

I consent to allow the doctors, associates and designated staff of the clinic to treat me with physical medicine modalities and manual spinal manipulation. I acknowledge there is a risk associated with such care and it could result in stroke, paralysis, dislocation, fracture or otherwise could worsen a condition. I hereby acknowledge and understand these risks and permit the treatment to begin and follow through to the end of care at this clinic**.**

PATIENT SIGNATURE _____ DATE _____
PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____
RELATIONSHIP TO PATIENT_____

GUARDIANSHIP CONSENT

I consent to all the doctors, associates and designated staff of the clinic to treat my child or ward (name and age of child or ward) _____ with physical medicine modalities and manual spinal manipulation.

PATIENT REPRESENTATIVE SIGNATURE _____
RELATIONSHIP TO PATIENT _____

CONSENT TO X-RAY

I authorize the performance of diagnostic X-Ray examination of myself which the doctor may consider necessary or advisable in the course of my examination and treatment.

PATIENT SIGNATURE _____ DATE _____
PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____
RELATIONSHIP TO PATIENT _____

I authorize the performance of diagnostic X-Ray examination of my child or ward, (name and age of child or ward) _____ which the doctor may consider necessary or advisable in the course of examination and treatment.

PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____
RELATIONSHIP TO PATIENT _____ DATE_____

NON-PREGNANCY STATEMENT

I certify that, to the best of my knowledge, I am not pregnant (or the above-mentioned child or ward is not pregnant) and the above doctor or associates have my permission to perform said diagnostic X-Ray examination. I have been advised that X-Rays can be hazardous to an unborn child.

PATIENT SIGNATURE _____ DATE _____
PATIENT REPRESENTATIVE SIGNATURE _____ DATE _____
RELATIONSHIP TO PATIENT _____

PREGNANCY STATEMENT

I certify that, to the best of my knowledge, I am pregnant and gestation is approximately _____weeks into the stages of pregnancy.

PATIENT SIGNATURE _____DATE _____

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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 writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
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. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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 Date

Signature of Patient / Guardian Date