Hayes Sports Chiropractic

CASE HISTORY

Name ______________________________ Date ____________

Address ______________________________ City ____________ State ______ Zip ________

Cell Phone ______________ Home Phone ______________ Email Address ______________

Age __________ Birthdate __________ Sex ___ Status ☐M ☐S ☐W ☐D Spouse's Name ______________

if minor, Parent's name ______________ Cell Phone ______________ Home Phone ______________

Person Responsible for this account ______________ Referred By ______________

Occupation ______________ How long since you've felt good? ______________

What is your major complaint? ______________________________

____

Other Complaints ______________________________

How long have you had this condition? ______________ Have you had this or similar conditions int he past? ________

What activities aggravate your condition? ______________________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with our: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other: ______________

List surgical operations ______________________________

Are you taking any medications? ______________ What kind? ______________

Are you taking non-prescription drugs? ______________ What kind? ______________

OTHER DOCTORS SEEN FOR THIS CONDITION

Name ______________________________ Diagnosis ______________________________

X-rays ______________ Urinalysis ______________ Blood Tests ______________ Other ______________

Treatment Medication ______________________________ Physical Therapy ______________________________

Results ______________________________ Length of time under care ______________

Were you off work? ________ If so, how long? ________ Have you returned to the same job? ______________

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable.

______________________________ ______________________________

Patient's Signature Date

IMPORTANT: Please check (X) all present symptoms

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migrane
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck Pain with movement
  - ☐ forward
  - ☐ backward
  - ☐ turn to left
  - ☐ turn to right
  - ☐ bend to left
  - ☐ bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasm in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

ARMS AND HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins and needles in arms
- ☐ Sensation of pins and needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

MID-BACK:
- ☐ Mid-back pain
- ☐ Location: ______________________
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle Spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat:

  ____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
- ☐ Upper lumbar
- ☐ Lower lumber
- ☐ Sacroiliac
- ☐ Low back pain is worse when:

  ____
- ☐ Working
- ☐ Lifting
- ☐ Stomping
- ☐ Standing
- ☐ Sitting
- ☐ Bending
- ☐ Coughing
- ☐ Lying down (sleeping)
- ☐ Walking
- ☐ Pain reduced when:

  ____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIP, LEGS, AND FEET:
- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Pain down leg
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ inside
  - ☐ outside
- ☐ Leg cramps
- ☐ Cramps in feet
- ☐ Pins and needles in legs
- ☐ Numbness of leg
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles
- ☐ Swollen feet

WOMEN ONLY:
- ☐ Menstrual pain (where) ______________
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle (days) ______________
- ☐ Birth control (type) ______________
- ☐ Hysterectomy
- ☐ Genital cancer ______________
- ☐ Discharge
- ☐ Menopause
- ☐ Tumors
- ☐ Abortions
- ☐ Are you/do you think you are pregnant

MEN ONLY:
- ☐ Urinary frequency ______________
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostrate pain / swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep __________ hrs/night
- ☐ Loss of sleep __________ hrs/night
- ☐ Gain weight __________ lbs
- ☐ Coffee __________ cups/day
- ☐ Tea __________ cups/day
- ☐ Cigarettes __________ pack/day
- ☐ Other ______________________
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS:

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Patient's Signature

____

Date

INSURANCE ASSIGNMENT, RELEASE OF INFORMATION AND AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for the services rendered. If my insurance requires a referral and I receive care without proper authorization, I understand that I am financially responsible for all charges whether or not paid by my insurance company. (ie. Co-insurance, co-pay, deductible) I hereby authorize the doctor to verify healthcare benefits with my insurance company; to release all information necessary to secure the payment of my benefits and to authorize the use of this signature on all insurance submissions.

A copy of this document shall be considered as a valid original.

Print Patient Name	Patient or Guardian Signature	Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that my doctor acts in strict accordance with federal privacy regulations (HIPAA) and that I may request my own copy of the doctor's Notice of Privacy Practices for Protected Health Information at any time.

Print Patient Name	Patient or Guardian Signature	Date

COMMUNICATION AUTHORIZATION

I acknowledge that my doctor (or office staff) may need to contact me with appointment reminders, or other health related information. If this contact is made by phone and I am not at home, a message will be left on my answering machine or with the person who answers the phone. This contact may also be made by postal mail.

Patient or Guardian Signature	Date

INFORMED CONSENT FOR EXAMINATION AND CARE

I request and consent to the performance of physical examination and treatment on me or the patient named below for whom I am responsible by any licensed doctors or authorized providers in the office. I acknowledge that chiropractic care has possible (and extremely unlikely) complications including but not limited to fracture, dislocation, stroke, sprains and strains and muscular discomfort. I do not expect the doctor to anticipate all potential risks or complications and I wish to rely on the doctor to exercise clinical judgment in my best interest during the entire course of my care, based on the facts known at the time. I understand that I may have to speak to the doctor and ask questions about potential risks or any other concerns I may have at any time, including before I sign this acknowledgment and receive any physical evaluations or treatment. If the patient named below for whom I am responsible is under the age of 18, I hereby authorize treatment under the same conditions as noted above.

Print Patient Name	Patient or Guardian Signature	Date

Witness Signature