

Chiropractic Case History

Name _____ Sex M F Married ___ Single ___ Divorced ___ Date _____

Address _____ City _____ State _____ Zip _____

Home _____ Work _____ Cell _____ Date of Birth _____

Referred by _____ Social Security # _____

Occupation _____ Employer _____

Email _____ I would like to receive email notifications from this office.

1. Primary reason(s) for seeking chiropractic care:

Primary reason (Chief Complaint): _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint:

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

4. Past Health History:

Previous major illnesses, injury or trauma: _____

Allergies: _____

Medications: _____ Reason for taking: _____

Surgeries/Date: _____ Type of Surgery: _____

Females – Pregnancies/Date of Delivery: _____ Outcome: _____

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

Deaths in immediate family: _____ Age at death _____
Cause of parents or siblings death _____

6. Social and Occupational History:

Level of Education: high school some college college graduate post graduate studies

Job description: _____

Work schedule: _____

Recreational activities: _____

Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Functional Rating Index

For use with neck and/or back problems only. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0- No Pain	1- Mild Pain	2- Moderate Pain	3- Severe Pain	4- Worst Possible Pain
------------	--------------	------------------	----------------	------------------------

2. Sleeping

0- Perfect Sleep	1- Mildly Disturbed	2- Moderately Disturbed	3- Greatly Disturbed	4- Totally Disturbed Sleep
------------------	---------------------	-------------------------	----------------------	----------------------------

3. Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions	1- Mild Pain; No Restrictions	2- Moderate Pain; Go Slowly	3- Moderate Pain; Some Assistance	4- Severe Pain; 100% Assistance
-------------------------------	----------------------------------	--------------------------------	--------------------------------------	------------------------------------

4. Travel (driving, etc.)

0- No Pain on Long Trips	1- Mild Pain on Long Trips	2- Moderate Pain on Long Trips	3- Moderate Pain on Short Trips	4- Severe Pain on Short Trips
-----------------------------	-------------------------------	-----------------------------------	------------------------------------	----------------------------------

5. Work

0- Usual Work + Extra	1- Usual Work, No Extra	2- 50% of Usual Work	3- 25% of Usual Work	4- Cannot Work
-----------------------	-------------------------	----------------------	----------------------	----------------

6. Recreation

0- All Activities	1- Most Activities	2- Some Activities	3- Few Activities	4- No Activities
-------------------	--------------------	--------------------	-------------------	------------------

7. Frequency of Pain

0- No Pain	1- Occasional (25%)	2- Intermittent (50%)	3- Frequent (75%)	4- Constant (100%)
------------	---------------------	-----------------------	-------------------	--------------------

8. Lifting

0- No Pain with Heavy Weight	1- Increased Pain with Heavy Weight	2- Increased Pain with Moderate Weight	3- Increased Pain with Light Weight	4- Increased Pain with Any Weight
---------------------------------	--	---	--	--------------------------------------

9. Walking

0- No Pain with Any Distance	1- Increased Pain after 1 Mile	2- Increased Pain after ½ Mile	3- Increased Pain after ¼ Mile	4- Increased Pain after Any Distance
---------------------------------	-----------------------------------	-----------------------------------	-----------------------------------	---

10. Standing

0- No Pain with Any Time	1- Increased Pain after Several Hours	2- Increased Pain after 1 Hour	3- Increased Pain after ½ Hour	4- Increased Pain after Any Time
-----------------------------	--	-----------------------------------	-----------------------------------	-------------------------------------

Total _____ (/4, X10) = Functional Rating Score _____ %

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____

Lakeline Chiropractic
Dr. Tyson Krugman, D.C.
1525 Cypress Creek Road, Suite O Cedar Park, Texas 78613
P 512.401.2008 F 512.401.2145

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: X _____ Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

I instruct checks to be made payable to Krugman Family Chiropractic, 1525 Cypress Creek Rd, Ste O Cedar Park, TX 78613.

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Patient or Parent Signature: X _____ Date: _____

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

• I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of Lakeline Chiropractic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: X _____ Date: _____