BACK IN MOTION FAMILY AND SPORTS CHIROPRACTIC
17 Leroy Street Potsdam, NY 13676

Chiropractic Case History **Today's Date:** ____/____/_____

Name _____ **What you prefer to be called** _____ **Sex** M F
Address _____ **City**_____ **State**_____ **Zip**_____
Phone_____ Hm Wk Cell **Alternate Phone**_____ Hm Wk Cell
E-Mail _____**Social Security #** _____ **Birthdate** ___/___/_____ **Age**_____
Employer _____ **Occupation** _____ **Marital Status:** S M D W
Have you ever been to a chiropractor? __Yes __No **If yes, month/year of last visit** ___/____ **Referred by** _____

1. Primary Reasons for Seeking Care: (Ex: Pain Relief, Gain Mobility/Flexibility, Sleep Better, Be able to do… again, etc.)
Primary Reason: _____ Secondary Reason: _____

2. Chief Complaint: _____ ____ New Injury ____ Old Injury ____ Chronic Pain ____ Well Care
When did this complaint begin? _____
Did your injury/condition occur during: ____ Work ____ Auto Accident ____ Sports/Play ____ Routine Activity ____ Other
Describe initial cause of complaint? _____
Is your condition getting worse? _____ Yes _____ No ____Constant ____ Comes and goes
Have you had this or a similar condition before? ____ Yes ____ No Explain _____
Are you presently under a doctor's care for this complaint? ____Yes ____No Clinic/Doctors name:_____
Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging tingling/numbness
Does this complaint/pain radiate or travel (shoot) to other areas of your body? ____Yes ____No Where? _____
Do you have any numbness or tingling in your body? ____Yes ____No Where? _____
What aggravates the complaint? _____
What makes the complaint better? _____
Is your complaint interfering with your ____ Work ____ Sleep ____ Daily Routine If so, how? _____
Are you taking any of the following medications? ____ Pain Killers ____ Muscle Relaxers ____ Blood Thinner ____ Insulin
____ Tranquilizers ____ Nerve Pills ____ Other:_____
Are there any other health concerns you would like to address? _____

3. Previous interventions: (treatments, medications, surgery, or other care you've sought **for your chief complaint**)
_____

4. Past Health History:
Previous serious medical conditions (dates)**:** _____
Previous accidents/injury/trauma (dates)**:** _____
Have you ever broken any bones? Which? _____
Allergies: _____
Other Medications (not listed above)**:** _____
Conditions you are taking medications for: _____
Surgeries (dates): _____

5. Family Health History:
Mother: ____Living ____Deceased Health Issues/Cause of death _____
Father: ____Living ____Deceased Health Issues/Cause of death _____
Siblings: ____Living ____Deceased Health Issues/Cause of death _____

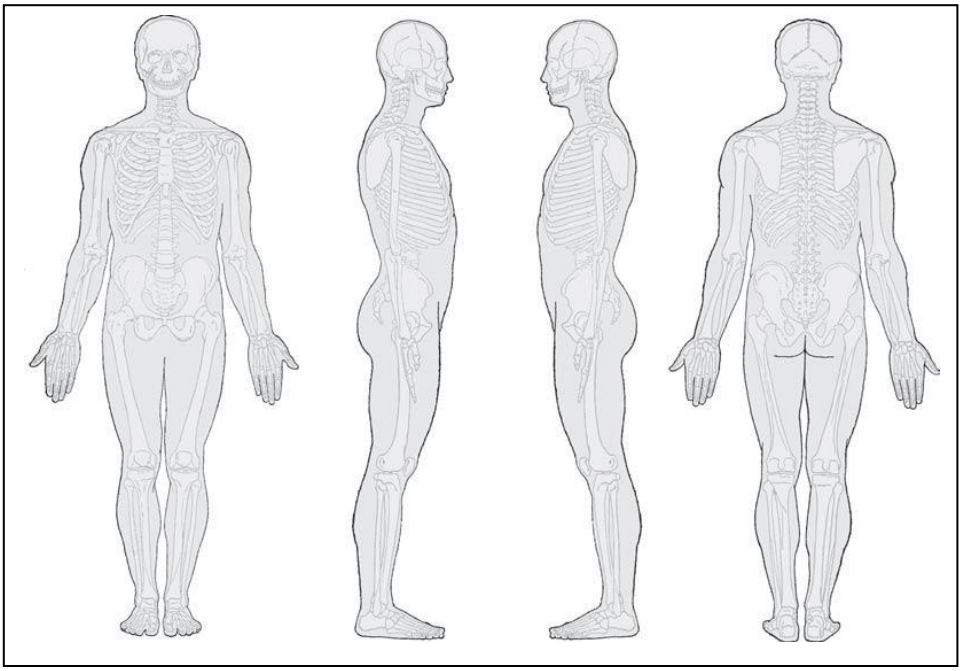
6. Social and Occupational History:
Activities required at work/job description: _____
Recreational activities: _____
Sleep hrs/night _____ Exercise hrs/week_____ Types of exercise _____
Do you take vitamins or supplements? ____ Yes ____ No Do you smoke? ____Yes ____No # packs/day _____ #years _____
Alcohol drinks/week _____ Caffeine cups/day _____ Are you wearing? ____ Shoe Lifts ____ Arch Supports

Circle the number that represents your avg. pain: (1 = discomfort, 10 = intense) 1 2 3 4 5 6 7 8 9 10

Using the pictures and symbols shown below, mark the location and type of pain you feel.

Symbols

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^



Please mark any of the following conditions or symptoms that you have now or have experienced:

O Severe/Freq. Headaches
O Neck Pain
O Sleeping Problems
O Low Back Pain
O Nervousness
O Tension
O Irritability
O Dizziness
O Pain between Shoulders
O Neck Stiffness
O Joint Swelling
O Fever
O Loss of Balance
O Ringing in Ears
O Jaw/TMJ Problems

O Pain in Hands or Arms
O Numbness in Hands or Arms
O Pain in Legs or Feet
O Numbness in Legs or Feet
O Fatigue
O Depression
O Lights Bother Eyes
O Loss of Memory
O Shoulder Pain
O Sinus
O Shortness of Breath
O Asthma/Emphysema
O Allergies
O Cold Hands or Feet
O HIV+/AIDS/ARC

O Chest Pains
O Heart Attack
O High Blood Pressure
O Stroke
O Cancer
O Painful Urination
O Diabetes
O Diarrhea
O Constipation
O Stomach Upset
O Heartburn/Reflux
O Weight Loss
O Alcohol/Drug Abuse
O Psychiatric Problems
O Heart Surgery/Pacemaker

FOR WOMEN ONLY:

__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
__ Menopause

Pregnant at this Time ____ Yes ____No
Date of Last Menstrual Period _____
Pregnancies, Date of Deliveries, and Outcomes (list in the space provided below):

INSURANCE INFORMATION:

Insurance Company_____ Phone_____
Insured's Name _____ Insured's Date of Birth _____
Insured's ID. # _____ Insured's Group # _____
Spouse's Name _____ Spouse's Date of Birth _____
Spouse's Employer _____Spouse's Phone (Work)_____
Spouse's Insurance Co. _____ Phone_____
Spouse's I.D. # _____ Spouse's Group # _____
Present condition due to an injury? Yes __ No __ On the Job __ Auto Accident __ Other _____
Has the accident been reported? Yes __ No __ To Employer __ Auto Carrier __ Other _____

I understand that it is my financial responsibility to pay for services that are not covered by my insurance company. Initial _____

EMERGENCY CONTACT: Name _____ Phone # _____

TERMS OF ACCEPTANCE:

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation/adjustment are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness may occur especially within the first few treatments similar to muscle soreness after exercise, Temporary dizziness and nausea may be experienced but are relatively rare. Fractures and joint injury can occur and is usually associated with underlying conditions such as physical defects, deformities, and pathologies like weak bones from osteoporosis. When these conditions are detected this office will proceed with extra caution.

There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely rare.

Our only practice objective is to reduce and/or eliminate musculoskeletal conditions through manual therapy; however, we may use other procedures to help your body hold the adjustments. The beneficial effects of our procedures include decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of these procedures. If this office encounters non-chiropractic findings we will advise you and recommend the appropriate health care provider.

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I have read and fully understand the above statements and I agree to allow this office to examine me for further evaluation.

Signature _____ Date _____

HIPAA AUTHORIZATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this authorization. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initial: _____ Reason: _____

Assignment of Benefits

Patient: _____
ID #: _____
Insurance Company: _____

I, _____, being insured under provisions of the above-enumerated policy, specifically direct you, the Insurance Company to make payment directly to Back In Motion Family and Sports Chiropractic for my chiropractic services.

Please send payment to:

Back In Motion Family and Sports Chiropractic
17 Leroy Street
Potsdam, NY 13676

As the owner/beneficiary under this policy, I hereby direct that reimbursement for ALL OF THE SERVICES I RECEIVED AT BACK IN MOTION FAMILY AND SPORTS CHIROPRACTIC BE PAID DIRECTLY TO THE PROVIDING DOCTOR AT THEIR OFFICE. Payment is to be made under the terms of the policy. If my policy does not allow for payment directly to the provider, then I hereby direct that payment be issued with my name, as well as the name of the providing doctor, on the check.

I thank you for your cooperation in this matter,

_____ _____
Patient/Beneficiary Date

Missed, Cancelled, and Late Appointment Policies Form

If you cannot make your appointment, we require ***at least* 24 hour advanced notice**.

If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. Your consideration is appreciated because the sooner you call us the greater our chances of providing this time to someone else. Appointment times are very important to our patients as well as to us. When a patient fails to keep an appointment, this time goes unused. Even on short notice, another patient could have benefited from your appointment time. By implementing this policy, it is our goal to make as many appointments available to our patients as possible.

If a person fails to show for an appointment and/or does not provide at least 24 hour notice prior to cancelling then we will charge a fee of **$50.00** for the missed appointment. This fee must be paid in full before being scheduled for another visit. These charges will not be billed to your insurance provider. Your appointment time is allotted to you, so we will charge you for failure to call. A message left on our answering machine during or after office hours is fine, as long as it is left at least 24 hours prior to your scheduled visit.

This policy applies to the following missed appointments:

The individual was **previously informed** of this policy.
The cancellation was **not** due to a **medical emergency**.
The individual **failed to cancel** with at least **24 hours notice**.
Effort was made by our office to give a reminder for the missed appointment.

Late Appointment Arrivals

We ask for you to plan to arrive on time for your appointment. We operate on a schedule, and try our best to keep patients from having to wait. If you arrive **more than 10 minutes late** for your appointment, we may choose to reschedule your appointment and charge you the **$50.00** missed appointment fee. If we choose to see you, your appointment time may be reduced and you will still be responsible for the full fee.

Multiple "no shows" may result in being discharged from this office.

We also recognize that life isn't perfect and that there are circumstances that are out of your control (sudden illness, family emergency, etc.) and so we may make an exception to the above policies in those rare occasions.

Preferred method for reminders: (circle one) Phone Call E-mail Text FB message
Best Phone # / E – Mail address: _____

Thank you for your cooperation in helping us to provide the best care possible!

Print Name _____

Signature: _____ **Date:**_____