Solecki Chiropractic Case History

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

Name: _____ Social Security #: _____ Age: _____ Birth Date: _____ Marital: Divorced

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Home Phone: _____ Cell Phone: _____

Contact Preference: ☐ Hm PH ☐ Cell Ph ☐ Txt MSg(*Please list cell ph carrier_____*) ☐ Wk Ph

Language: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Other

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African America ☐ Asian ☐ American Indian ☐ Other

Occupation: _____ Employer: _____ 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? ☐ Yes ☐ No

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? ☐ Yes ☐ 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)*

☐ Diabetes Type I	☐ Broken or Fractured Bones	☐ Osteoarthritis	☐ Eating Disorder	☐ Ulcers
☐ Diabetes Type II	☐ Circulatory Problems	☐ Epilepsy	☐ Rheumatoid Arthritis	☐ Pace Maker
☐ High Blood Pressure	☐ Drug Addiction/Alcoholism	☐ Strokes	☐ Seizures/Convulsions	☐ Cancer
☐ HIV Positive	☐ A Congenital Disease	☐ Gall Bladder	☐ Excessive Bleeding	☐ Ruptures
☐ Depression	☐ High/Low Blood Pressure	☐ Coughing Blood		

Patient's Signature: _____ Date: _____

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):*

_____

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

If yes, describe: _____

What medications or drugs are you 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:* _____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? No **If so, how much per week?** _____

Do you use any tobacco products? No **Do you smoke?** ☐ **Never** ☐ **Former Smoker** ☐ **Current/Every day** ☐ **Current Some Day**

Do you take vitamin supplements? No **If so, please list:** _____

Do you consume caffeine? No **If so, how much per day:** _____

Do you exercise? No **If yes, what is the frequency and type of exercise?** _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home**) do you spend:** lifting ___ sitting ___ bending ___

FAMILY HISTORY:

Father: living☐ deceased☐ Current age if still living: ☐ Cause of death and age at death if deceased: _____

Mother: living☐ deceased____ Current age if still living: ____ Cause of death and age at death if deceased: _____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

_____

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

B Tuberculosis B Cancer B Mental Illness B Diabetes B Asthma B Liver Disease

B Heart Disease B Stroke B Kidney Disease B Lung Disease B Arthritis B Other

Patient's Signature: _____ **Date:** _____

PAIN QUESTIONNAIRE

Patient Name: _____ Date _____

Instructions: These questions ask your views about how your pain affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you CURRENTLY feel.

1. Does your pain interfere with your normal work inside and outside the home? Work normally Unable to work
10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)? Take care of self completely Need help with all personal care
10

3. Does your pain interfere with your traveling? Travel anywhere I like Only travel to see doctors
10

4. Does your pain affect your ability to sit or stand? No problems Can not sit/stand
10

5. Does your pain affect your ability to lift overhead, grasp objects or reach for things? No problems Cannot do
10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat? No problems Cannot do
10

7. Does your pain affect your ability to walk or run? No problems Can not walk/run
10

8. Do you have to take pain medication every day to control your pain? No medication needed On pain medication
10

9. Does your pain force you to see doctors much more often than before your pain began? Never see doctor See doctor weekly
10

10. Does your pain interfere with your ability to see the people who are important to you as much as you would like? No problem Never see them
10

11. Does your pain interfere with recreational activities and hobbies that are important to you? No interference Total interference
10

12. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain? Never need help Need help all the time
10

13. Do you now feel more depressed, tense, or anxious than before your pain began? No depression/tension Severe depression/tension
10

14. Are there emotional problems caused by your pain that interfere with your family, social and or work activities? No problems Severe problems
10

___ _____
Examiner

OTHER COMMENTS: _____

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC INFORMED CONSENT

CHIROPRACTIC: It is important to acknowledge the difference between the healthcare specialties of Chiropractic, Osteopathy and Medicine. Chiropractic healthcare seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic healthcare services.

ANALYSIS: A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complex (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS: Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medicine specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE: A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis, and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a Chiropractic adjustment, or healthcare, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known if he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.
As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, costoverebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for while taking your medical history and during examination and X-ray. Stroke has been the subject of tremendous disagreement throughout the medical community, with one prominent authority stating that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. Other complications are also generally described as "rare".

RESULTS: The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.
In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

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.
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.
I have read and understand the foregoing

Patient's Signature: _____ **Date:** _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

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

I, _____ [Name of Individual] consent to Solecki Chiropractic & Physical Therapy Clinic, P.C.'s ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Name_____ Date_____
Print Patient's Name

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)