

# INTRODUCTION PATIENT CASE HISTORY

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Mobile #: \_\_\_\_\_  
Email: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: Single / Married / Other  
Date of Birth: \_\_\_\_\_  
Referred By: (Name): \_\_\_\_\_ Family / Friend / Co-worker / Doctor / Other Source  
Major Concern: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_  
Dr. Address: \_\_\_\_\_ Dr. Phone Number: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Name: (First, Last) \_\_\_\_\_ Mobile #: \_\_\_\_\_  
Relationship: Child / Parent / Spouse / Other: \_\_\_\_\_

## FINANCIAL INFORMATION

\_\_\_ Insurance \_\_\_ Worker's Comp \_\_\_ Self-Pay (Cash) \_\_\_ Personal Injury/Auto \_\_\_ Other

### PRIMARY INSURANCE

### SECONDARY INSURANCE

Insurance Name: \_\_\_\_\_ Insurance Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other Relation to Insured: Self / Spouse / Parent / Child / Other  
ID #: \_\_\_\_\_ ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Evaluation Date: \_\_\_\_\_

*It is Usual and Customary to Pay for Services Rendered Unless Otherwise Arranged*

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight \_\_\_\_\_ Lbs.

What body part are you here for today? \_\_\_\_\_ Left Right

When did this problem begin? \_\_\_\_\_

 Was there a specific injury?  Yes  No (if yes, please describe): \_\_\_\_\_

 Have you ever had physical therapy for this problem?  Yes  No

Have you had physical therapy this calendar year? Yes No

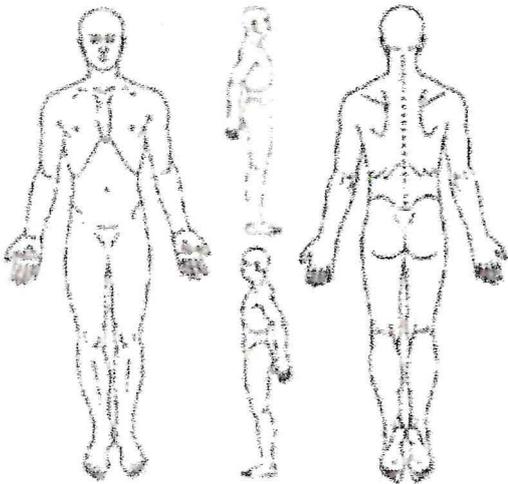
Have you had home care physical therapy for this problem? Yes No If yes, when were you discharged?

Is your injury work related? Yes No Is your injury related to a motor vehicle accident? Yes No

What is/are your main complaint(s)? Pain Numbness Stiffness Balance loss Other: \_\_\_\_\_

If you have pain, please rate your pain on a scale of 0 to 10 with 0 being no pain and 10 being the worst imaginable:

At this current time: /10 Worst in the past 24 hours: /10 Best in the past 24 hours: /10

 Please mark on the diagram with an X where it hurts  
Please mark any areas of numbness with O

**Medical History:** Please check any conditions that you have

- |                                               |                                                 |                                            |
|-----------------------------------------------|-------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> TIA (mini stroke) |
| <input type="checkbox"/> Heart Arrhythmia     | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> High BP           |
| <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Kidney Disease    |
| <input type="checkbox"/> Neuropathy           | <input type="checkbox"/> Acid Reflux            | <input type="checkbox"/> Osteoarthritis    |

Cancer Type: \_\_\_\_\_

Other: \_\_\_\_\_

 I do not have any medical problems

 List any orthopedic surgeries that you have had (including year):

 List any other surgeries that you have had:

 Are you allergic to latex?  Yes  No Do you have a pacemaker or defibrillator?  Yes  No Do you smoke? Yes No

Do you exercise regularly? Yes No Female Patients: Is there any possibility that you are pregnant? Yes No

 Review of Systems: Are you currently having, or have you had, problems with:  None Numbness or Tingling? Yes No  
Lungs or Breathing? Yes No Bleeding Disorders? Yes No Heart or Chest Pain? Yes No GI ulcers? Yes No

 Do you have any medication, food or environmental allergies?  Yes  No If Yes, please list: \_\_\_\_\_

**Diagnostic Testing:** Have you had any of the following tests for you current problem:

 X-Ray  MRI  CT scan  EMG / Nerve Conduction Study Other: \_\_\_\_\_

Results (if known): \_\_\_\_\_

**Medications:** Do you currently take any medications, vitamins, supplements or herbs?  Yes  No

If yes please fill out attached medication sheet or provide a current list.

**Goals:** Please list the goal(s) that you hope to achieve by attending physical therapy: \_\_\_\_\_

The above is true and correct to the best of my knowledge

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION  
APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION**

**Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information and/or billing records:

- to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- to another party if they are potentially responsible for payment of your services.
- within our practice for quality control or other operational purposes.

Our office may need to use your name, address, phone number, and clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form you are giving us authorization to contact you with these reminders and information.

**Your Rights To Limit Uses or Revoke Authorization**

You may restrict the individuals or organization to which your health care information is released or revoke your consent at any time; however, your revocation must be in writing. We are not required to agree to your restrictions. However, if we agree, the restriction is binding on us. We will not be able to honor your revocation request if we have already released your health information before receiving your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose may be subject to re-disclosure by anyone who has access to this information and may no longer be protected by the federal privacy rules.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed and you have a right to review that notice before you sign this consent form (§164.520). You may inspect or copy information that we use to contact you to provide appointment reminders or other health care information at any time (§164.524). We reserve the right to change our privacy policies. If we make changes we will notify you when you come in for treatment or by mail.

This notice is effective as of \_\_\_\_\_ . This authorization will expire seven years after the date on which you last received services from our practice.

I have read your consent policy and authorize use or disclosure of my health information in the manner described above. I am also entitled to a copy of this or a detailed notice upon request.

\_\_\_\_\_  
PATIENT NAME PRINTED

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE (or parent if minor)

\_\_\_\_\_  
CLINIC REPRESENTATIVE SIGNATURE

\_\_\_\_\_  
PERSONAL REPRESENTATIVE PRINTED (optional)

\_\_\_\_\_  
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT.

Northampton Chiropractic Center DBA; Clearie Chiropractic - Community Care Physical Therapy, LLC.



### Insurance and Payment Policy

Our multi-discipline practice makes the best effort to know what financial responsibility our patients have at the time of service, as well as limitations of their insurance policies. We will charge according to the information we have at that time. However, there are constant changes in plans and other factors which may not give us the correct information. Should a discrepancy occur once an Explanation of Benefits (EOB) is received, you will either receive a credit on your account or be billed the difference. Deductibles are the responsibility of the patient at the time of service.

Our health center treats you, the patient, not your insurance, and will lay out a treatment course that is in your best interest. Should you exhaust your benefits, or your insurance company does not deem care medically necessary prior to the end of the treatment plan prescribed, you will be responsible for those visits on a cash-case basis.

Periodically, usually monthly, we must perform an examination to monitor your progress. This examination is at the discretion of the doctor(s) and you will be responsible for any additional charges according to your insurance. Again, our health center is treating you, not your insurance, and these examinations are necessary to give you the best care.

Furthermore, there will be a **\$25.00 cancellation fee** which will go into effect on January 1<sup>st</sup>, 2025, for any appointment cancelled less than 24 hours prior to scheduled appointment time. We thank you for understanding.

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I have read the above Insurance and Payment Policy. I understand that benefit quotes are not a guarantee of payment by my insurance company, and I will be responsible for any copay/co-insurance, deductibles, and services not covered or deemed medically necessary.

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PRINT PATIENT NAME

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DATE

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SIGNATURE OF RESPONSIBLE PARTY

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STAFF WITNESS

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