Confidential Case History- **Please Print.**

Patient Type: ☐ New Patient ☐ Existing Patient- New Injury/Episode

Name:_____ Date of Birth:_____ Date: _____

Primary Care Physician: _____

Who may we thank for referring you to our office? _____

Occupation:_____ Employer:_____

Main Complaint: 1)_____

2)_____

3)_____

When did it start? Date: _____ How did it start?_____

_____

Is the above condition(s) due to: □ Auto Accident □ Work-Related Injury □ Neither of these

How Would You Rate The ***Current*** Intensity Of Your Pain (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Extreme Pain)

Indicate the range of your symptoms since they began: (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Extreme Pain)

Have You Had Similar Pain In The Past Y or N If yes When:_____

Are you currently out of work due to this problem? Y N If yes, when did disability begin?_____

The symptoms began: □ Gradually □ Suddenly The Pain has been getting: □ Better □ Worse

Does you feel the pain in any other part of your body? If yes, where?_____

Is your pain □ 76-100% □ 51-75% □ 26-50% □ less than 25% of the day?

Which terms best describe your symptoms: □ Dull □ Sharp □ Achy □ Stabbing □ Radiating □ Tingling □ Numbness □ Burning □ Stiffness □ Weakness □ Soreness □ Other _____

What makes your increases your symptoms? □ Sitting □ Standing □ Walking □ Exercise □ Lying On Stomach □ Lying On Your Back □ Rotation □ Side Bending □ Looking Down □ Looking Up □ Touching Toes □ Leaning Backward □ Lifting □ Coughing □ Sneezing □ Rest □ Driving □ Typing/Computer Work □ Stair Stepping □ Changing Positions □ Other _____

What makes your symptoms better? □ Heat □ Ice □ Movement □ No Movement/Rest □ Ibuprofen/Aspirin □ Medications □ Sitting □ Standing □ Lying Down □ Support/Brace □ Stretching/Exercise □ Manipulation □ Other _____

Is your pain worse in the: □ morning □ afternoon □ evening □ night □ same all day

What doctors have you seen and tests have you done for this condition?_____

_____

What medication or home remedies have you tried for this problem?_____

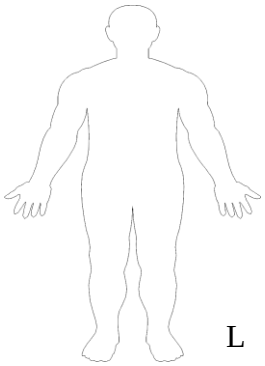
Have there been any other changes in any other body functions? Y N Explain:_____

Has your condition affected your daily activities or work in any way? Y N Explain:_____

What do you want to be able to do that your pain prevents? _____

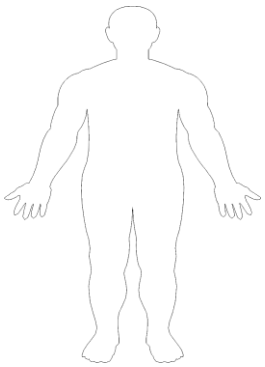
Indicate areas of discomfort: (indicate: /// pain, O pins & needles, X ache, = = = numbness)

Front



R L

Back



L R

Is your pain
__ sharp
__dull
__achy
__weak
__throbbing
__numb
__shooting
__gripping
__burning
__tingling

Patient Signature:_____ Date: _____

Patient Goals:

1)_____

2) _____

3) _____

_____
Dr. Initials/Date

Review of Systems

Patient Name:_____ Date Of Birth:_____

CHECK ALL THOSE THAT APPLY:

GENERAL APPEARANCE
□ Unexplained Weight Loss □ Unexplained Weight Gain □ Change in Sleeping Patterns □ Change in Activity

NEUROLOGICAL
□ Anxiety □ Headaches □ Depression □ Meningitis □ Paralysis □ Seizure □ Stroke □ Tingling □Tremors □ Memory Loss □ Fainting spells □ Dizziness □ Head injuries □ Blackouts or near blackouts □ Change in sensation anywhere on your body □ Localized weakness or numbness

EARS, EYES, NOSE, & THROAT
□ Hay fever □ Glaucoma □ Polyps □ Allergy □ Cataracts □ Goiter □ Hoarseness □ Double vision □ Gum problems □ Eye problems □ Ear Infections □ Glasses/contacts □ Hearing Loss □ Ear discharge/pain □ Frequent nosebleeds □ Ringing in your ears □ Sinus infections □ Swollen glands

CARDIOVASCULAR
□ Angina □ Leg cramps □ Ankle swelling □ Awakening at night short of breath & getting out of bed □ Cardiac catheterization □ Cold hands or feet □ Congenital heart defects □ Dizziness when standing up quickly □ Heart attacks □ Heart failure □ High or low blood pressure □ Irregular heart rate □ Purple fingers or lips □ Leg pain that resolves with rest □ Heart palpitations □ Varicose veins □ Chest pains □ Murmurs

RESPIRATORY
□ Asthma □ Breathlessness when lying flat □ Prolonged cough □ Coughing up blood □ Emphysema □ Shortness of breath □ Tuberculosis □ Pneumonia □ Frequent infections (bronchitis) □ Wheezing □ Pleurisy

SKIN
□ Abscess □ Dandruff □ Acne □ Oily skin □ Boils □ Rashes □ Hives □ Dry skin □ Lumps □ Psoriasis □ Jaundice □ Athlete's foot □ Excessive body odor □ Excessive sweating □ Fungal infections □ Nail problems □ Moles- irregular □ Moles - change/new

KIDNEYS & URINARY TRACT
□ Blood in urine □ Brown urine □ Dribbling after urination □ Painful urination □ Excessive thirst □ Involuntary urination/incontinence □ Urinating frequently (day) □ Urinating frequently (night) □ Urine hesitancy □ Weak flow □ Frequent bladder infections □ Kidney disease □ Kidney stone

ENDOCRINE
□ Diabetes □ Sickle cell □ Abnormal body hair □ Changes in skin texture □ Cold intolerance □ Heat intolerance □ History of "borderline" diabetes □ Hypothyroidism

MUSCULOSKELETAL
□ Anemia □ Arthritis □ Back pain □ Bursitis □ Gout □ Joint aches □ Neck pain □ Tendinitis □ Abnormal Blood Counts □ Blood clots in legs/lungs □ Bone Marrow Biopsy □ Easy Bleeding □ Easy bruising □ Joint swelling □ Morning stiffness □ Muscle aches

GASTROINTESTINAL
□ Diarrhea □ Reflux □ Ulcers □ Hepatitis □ Abdominal pain □ Anal fissures □ Black tarry stools □ Vomiting blood □ Constipation □ Nausea □ Problems swallowing □ Hiatal Hernia □ Intestinal obstruction □ Liver disease □ Hemorrhoids □ Red blood after bowel movements □ Gallstones □ Vomiting □ Heartburn □ Indigestion

Other Conditions Not Listed Above:_____

Current Medications: _____

Family Disease History: _____

Surgical History: _____

Musculoskeletal Injury History: _____

Do you currently smoke? □ Yes □ No Have You Smoked In The Past: □ Yes □ No

Do you consume alcohol? □ Yes □ No How many drinks per week: _____

_____ _____
I affirm that to the best of my knowledge the above is true (*patient signature)* Date

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy ___ palpation ___ vital signs ___ range of motion testing ___ orthopedic testing ___ basic neurological ___ muscle strength testing ___ postural analysis testing

_____

_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

• Self-administered, over-the-counter analgesics and rest
• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
• Hospitalization
• Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Bleam and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ Dated: _____

_____ _____
Patient's Name Doctor's Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that I have been provided an opportunity to review Freedom Chiropractic & Rehab's HIPAA policies.

I acknowledge that Freedom Chiropractic & Rehab may, at times, contact me via email or text messaging, without disclosing PHI, and I authorize them to do so.

_____ _____
Patient or Personal Representative Signature Date

_____
Printed Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

PATIENT _____

DOB _____

AUTHORIZATION & ASSIGNMENT

This is to certify that I have engaged Freedom Chiropractic & Rehab for professional services. I hereby authorize the following and will permit a photocopy to be considered as valid as the original, and may be used in lieu of the same.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Freedom Chiropractic & Rehab to release any appropriate information concerning my condition to any insurance company, attorney, or adjuster in order to receive reimbursement for any charges incurred by me as a result of services rendered at Freedom Chiropractic & Rehab.

I also authorize Freedom Chiropractic & Rehab to collect information that is necessary for and relevant to my treatment in the office.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

I authorize direct payment to you of any sum that I owe you now or in the future from any insurance company that is obligated to reimburse me for charges incurred in your office in part or full, or my attorney and other sources of benefits out of the proceeds of my settlement.

ASSIGNMENT OF CAUSE OF ACTION

I hereby assign and give you the right to take action against any insurance company that is obligated by contract to make payment to me. I authorize you to take action in either my name or your name to resolve this claim. It is understood that all reasonable efforts will be made to collect from the insurance company before I will be responsible for this bill. I do understand that whatever amounts are not collected from the insurance company will become my responsibility, and I am obligated to pay these charges upon receipt of a bill. I waive any claims arising under any statutes of limitations.

AUTHORIZATION TO USE LIKENESS IN PHOTOS OR VIDEOS

I authorize Freedom Chiropractic & Rehab and it's representatives to take photographs or videos of me. I grant them permission to use, exhibit, display, broadcast, and distribute these images in current or future media. I acknowledge that Freedom Chiropractic & Rehab owns all the right to the images or video. I hereby release, defend, indemnify, and hold harmless the producers from and against any claims, damages, or liability.

Patient Signature_____ Date_____

Parent Signature if patient is a minor_____