Date: ___________________

105 East South Street, Carey, OH 43316

Confidential Patient Information

Patients Name: ______________________________ Chief Complaint: __________________________

Address: ___________________________________ Home Phone: _____________________________

___________________________________ Cell: _______________Work:________________

Email: _____________________________________ SSN# _________ - ________ - _____________

Date of Birth: ______________________________ Marital Status: M S W D

Occupation: ________________________________ Employer: _______________________________

Referred by: ____

Are your present symptoms or condition related to, or the result of, an auto collision, work-related injury, or personal injury? (Someone else might be responsible for payment?) _____ Yes _____ No

Ins. Company: ______________________________ Ins. Phone #: _____________________________

ID#: ______________________________________ Group #: _________________________________

Name of Insured: ____________________________ Insured DOB: _____________________________

Family Physician: ___________________________________ (Note: We may send your health information to this provider)

Person to contact in case of emergency (Name and Phone): ____

Surgeries past 5 years? ____ When? ________________

____ When? ________________

Serious Illness: ____ When? ________________

Accidents/Injuries: ____ When? ________________

____ When? ________________

____ When? ________________

History of Cancer(s): ____ When?________________

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds ___

Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _________________________________

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Carey Chiropractic Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________________ ______________________

Signature of Insured / Guardian Date

Carey Chiropractic Center

105 East South Street, Carey, OH 43316 (419) 396-6343

Terms of Acceptance

Informed Consent:

A patient, in coming to the chiropractic physician, 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 problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Also, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient of Carey Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge (I am / am NOT pregnant) and (give my permission / don't give my permission) to x-ray me for diagnostic interpretation.
(please circle one) (please circle one)

Consent to Evaluate and Treat a Minor:

I, ________________________________ being the parent or legal guardian of ______________________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information to your friends and family, to whom may we do so?

Spouse: ____

Children: ____

Others: ____

May we leave messages on any answering device, i.e. home answering machines or voicemails? [ ] Yes [ ] No

Acknowledgement:

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

I, ____, have read and fully understand the above statements.

Signature: ____ Date: ____________________

Carey Chiropractic Center - Scott E. Griffin, D.C.
105 East South Street, Carey, Ohio 43316
(419) 396-6343 (p) ~ (419) 396-3098 (f)

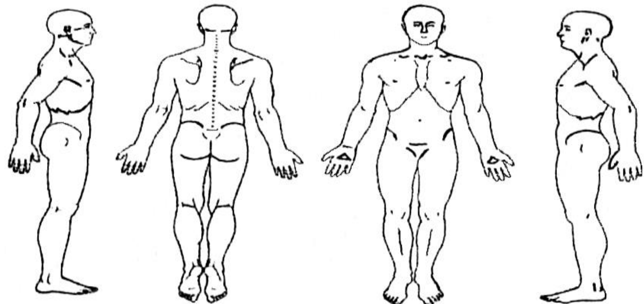
CASE HISTORY

Name: ___________________________________

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal … Severe)	Frequency (% of week) (Occasional … Constant)
a.______________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b.______________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c.______________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d.______________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e.______________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are <u>worse</u> in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? ______________________________
6. How did your symptoms begin? ______________________________
7. Have you experienced these before? ______________________________
8. Do your symptoms radiate? ______________________________
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: ______________________

    If No, what have you tried that has not helped? ______________________________

12. Have you been treated for this before? ____No ____Yes How long ago? ______________________
13. What treatment did you receive? ______________________________
14. Results of previous treatment? ____Good ____Poor Comments ______________________
15. Were you referred to our office by anyone? ______________________________
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: ______________________

____

18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature ______________________________ Date: ______________