

INTRODUCTION PATIENT CASE HISTORY

Name: _____ Date: _____

Preferred Name: _____ Email: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Mobile #: _____

Gender: M F Marital Status: Single Married Other

Social Security #: _____ Date of Birth: _____

Referred By: _____ Existing Patient Insurance Internet: Google/Yahoo/Yelp Other Source

EMERGENCY CONTACT INFORMATION

Name: _____ Home: _____ Mobile: _____

Relationship: Child Parent Spouse Other: _____

Primary Care Physician: _____ Doctor's Phone: _____

FINANCIAL INFORMATION

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

SYSTEMS REVIEW Please check all of the following that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Stroke Date: _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Numbness in Groin / Buttocks | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Cancer / Tumor (explain) _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Medications: _____ |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, prednisone, etc.) | _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Recent Fall Date: _____ | _____ |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Other Health Problems (explain) _____ |
| | _____ |

PLEASE FEEL FREE TO USE REVERSE SIDE OF PAPER – Copies of Medications/Surgeries Welcome

FAMILY HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Problems/ Stroke | <input type="checkbox"/> Rheumatoid Arthritis | |

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED

HISTORY OF CURRENT CONDITION

NAME: _____ DATE: _____

Major Complaint: _____

When did it start (Date): _____ What event caused it: _____

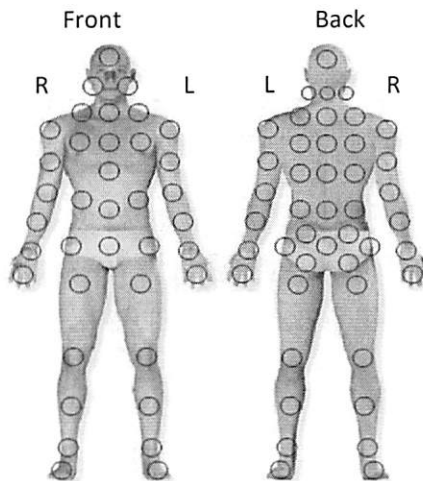
Intensity: None (0) Mild (1-2) Mild-Moderate (2-4) Moderate (4-6) Moderarate–Severe (6-8) Severe (8-9)

Is the complaint New / Reoccurring Does it Radiate to additional area of your body? No / Yes

If Yes Where: _____

Is the complaint: Aching / Dull / Burning / Sharp / Stabbing / Stiff / Numb-tingling / Other: _____

Have you had this condition before? Yes / No



Mark areas of complaint

Is the complaint getting : Better / Same / Worse from when it started most recently?

How often do you feel the discomfort? 16+ hours / 10-16 hours / 7-10 hours / 3-7 hours / 1-3 hours

What makes it feel better: Ice / Heat / Rest / Massage / Stretching / OTC Meds / RX Meds / Other: _____

Who else have you seen for this complaint: No One / Chiro / MD / PT / Massage / ER / Other: _____

Diagnostic Tests: None / X-rays / MRI / CT / Other: _____ Where & When _____

What makes it feel worse: (Check below)

	Immediately	After 5 min.	After 10 min.	Other		Immediately	After 5 min.	After 10 min.	Other
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household Chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lie Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					(other)				

Where is your #2 COMPLAINT located??? and DESCRIBE IT

Surprise Chiropractic

14545 West Grand Avenue, Suite A106, Surprise, AZ 85374

623-544-9111 – Office / 623-544-9333 - Fax

Dr. Louis V. Verloop, D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of therapeutic procedures, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here Dr. Louis V. Verloop and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Louis V. Verloop, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the chiropractic physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the chiropractic physician to exercise judgment during the course of the procedure which the chiropractic physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractic physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the *Patient*:

Print Name of Patient

Signature of Patient

To be completed by the *Patient's Representative*, if patient is a minor or is physically or mentally incapacitated:

Print Name of Patient

Print Name of Representative

Signature of Representative

Form to be maintained in the patient's health record.

SURPRISE CHIROPRACTIC

Louis Verloop, D.C

14545 W Grand Ave suite # A106, Surprise, AZ 85374

P : 623-544-9111 F: 623-544-9333

• **INSURANCE INFORMATION**

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and that the fees for the professional services rendered to me will be immediately due and payable.

Initial: _____

• **ASSIGNMENT OF BENEFITS**

I hereby authorize Surprise Chiropractic, LLC to release any information necessary to process this claim and assign ALL BENEFITS payable directly to Surprise Chiropractic, LLC.

I waive the Statute of Limitations regarding my chiropractic physician's right to recover.

I understand that whatever amount is not collected from insurance proceeds, (whether it be all or part, when insurance benefits exhaust or are denied for whatever reason), I am personally responsible.

If collection or legal action should become necessary in payment of services rendered by Surprise Chiropractic, LLC, I understand that I will be personally responsible for all fees incurred by Surprise Chiropractic, LLC, made to collect that payment due.

Initial: _____

• **CONSENT OF PROFESSIONAL SERVICES & RELEASE OF INFORMATION**

I hereby authorize and release the chiropractic physician and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person of corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, workers compensation carriers, welfare funds, or the patient's employer.

Initial: _____

• **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand that 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 healthcare providers who may be directly and indirectly

involved in providing my treatment.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and accreditation.

- We can accommodate your need for further privacy or information if you deem necessary, please let us know.

Initial: _____

By initialing the above and signing this document, I acknowledge and understand my rights as a patient.

Printed Name: _____ **DOB:** _____

Patient Signature: _____ **DATE:** _____