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.**

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

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

FAMILY HISTORY

- ☐ Cancer
- ☐ Heart Problems/ Stroke
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ High Blood Pressure

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

SURPRISE CHIROPRACTIC
Louis Verloop, D.C
14515 W Grand Ave suite #C128, 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 waiver 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:**____________

Surprise Chiropractic

14515 West Grand Avenue, Suite C128, 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.

HISTORY OF CURRENT CONDITION

NAME:____ **DATE:**__________________

Major Complaint: ____

When did it start (Date): ____________________ **What event caused it:** ______________________

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

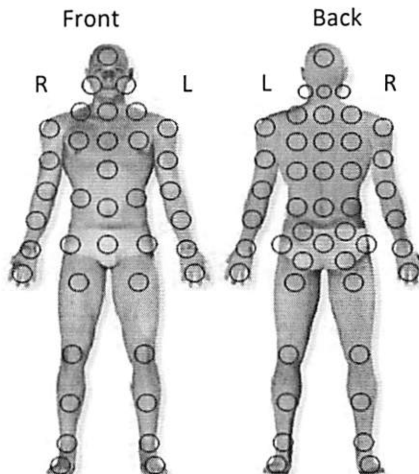
If **Yes** Where: ____

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

Have you had this condition before? Yes / No

Please Circle Pain Intensity Below

Mark areas of complaint



0: No Pain

1-2: Mild Pain

2-4: Mild - Moderate Pain

4-6: Moderate Pain

6-8: Moderate - Severe Pain

8-9: Severe Pain

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	☐	☐	☐	☐	*Sit*	☐	☐	☐	☐
Walking	☐	☐	☐	☐	*Household Chores*	☐	☐	☐	☐
Drive Car	☐	☐	☐	☐	*Reach overhead*	☐	☐	☐	☐
Cooking	☐	☐	☐	☐	*Use computer*	☐	☐	☐	☐
Lie Down	☐	☐	☐	☐	________ ***(other)***	☐	☐	☐	☐

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

____