

Chiropractic Case History

Name _____ Sex M F Married ___ Single ___ Divorced ___ Date _____

Address _____ City _____ State _____ Zip _____

Home _____ Work _____ Cell _____ Date of Birth _____

Referred by _____

Occupation _____ Employer _____

Email _____

Have you ever received Chiropractic Care? Yes No If yes, when & by who? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous treatments, medications, surgery, or care you've sought for your complaint: _____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

Have you ever broken any bones? _____

C. Medications:

Medication

Reason for taking

_____	_____
_____	_____
_____	_____

D. Others surgeries:

_____	_____
_____	_____
_____	_____

E. ARE YOU PREGNANT OR THINK YOU ARE PREGNANT AT THIS TIME?_ YES OR NO

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

MOTHER/ FATHER HEALTH ISSUES _____

6. Social and Occupational History:

A. Level of Education:

high school some college college graduate post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

BUTLER CHIROPRACTIC CLINIC
1501 CROSS TIMBERS ROAD #200
FLOWERMOUND, TEXAS 75028

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.
Assignment and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to be paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt my settlement award(s).

Patient Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

Patient Signature: _____ Date: _____

HEALTH ANALYSIS

No. _____ Date _____
 Patient _____ Home Phone (_____) _____
 Address _____ City _____ State _____ Zip _____
 Marital Status: Single Married Widowed Separated Divorced
 Age _____ Occupation _____

Please Circle the Appropriate Answer.

- | | | | |
|-------|---|-----|----|
| 1. | Do you need glasses to read? | Yes | No |
| 2. | Do you need glasses to see things at a distance? | Yes | No |
| 3. | Has your eyesight often blacked out completely? | Yes | No |
| 4. | Do your eyes continually blink or water? | Yes | No |
| 5. | Do you often have bad pains in your eyes? | Yes | No |
| 6. | Are your eyes often red or inflamed? | Yes | No |
| 7. | Are you hard of hearing?..... | Yes | No |
| 8. | Have you ever had a fluid leaking from your ear?..... | Yes | No |
| 9. | Do you have constant noises in your ears? | Yes | No |
| <hr/> | | | |
| 10. | Do you have to clear your throat constantly?..... | Yes | No |
| 11. | Do you often feel a choking lump in your throat?..... | Yes | No |
| 12. | Are you often troubled with bad spells of sneezing? | Yes | No |
| 13. | Is your nose continually stuffed up? | Yes | No |
| 14. | Do you suffer from a constantly running nose?..... | Yes | No |
| 15. | Have you at times had bad nose bleeds?..... | Yes | No |
| 16. | Do you often catch severe colds? | Yes | No |
| 17. | Do you frequently suffer from heavy chest colds? | Yes | No |
| 18. | When you catch a cold, do you always have to go to bed?..... | Yes | No |
| 19. | Do frequent colds keep you miserable all winter?..... | Yes | No |
| 20. | Do you get hay fever?..... | Yes | No |
| 21. | Do you suffer from asthma?..... | Yes | No |
| 22. | Are you troubled by constant coughing? | Yes | No |
| 23. | Have you ever coughed up blood? | Yes | No |
| 24. | Do you wake up drenched with sweat during the middle of the night?..... | Yes | No |
| 25. | Have you ever had a chronic chest condition?..... | Yes | No |
| 26. | Have you ever had T.B. (tuberculosis)? | Yes | No |
| 27. | Did you ever live with anyone who had T.B.? | Yes | No |
| <hr/> | | | |
| 28. | Has a doctor ever said your blood pressure was too high? | Yes | No |
| 29. | Has a doctor ever said your blood pressure was too low? | Yes | No |
| 30. | Do you have pains in the heart or chest? | Yes | No |
| 31. | Are you often bothered by thumping of the heart? | Yes | No |
| 32. | Does your heart often race like mad? | Yes | No |
| 33. | Do you often have difficulty in breathing?..... | Yes | No |
| 34. | Do you get out of breath before anyone else? | Yes | No |
| 35. | Do you sometimes get out of breath just sitting still?..... | Yes | No |
| 36. | Are your ankles often badly swollen? | Yes | No |
| 37. | Do cold hands or feet trouble you, even in hot weather? | Yes | No |
| 38. | Do you suffer from frequent cramps in your legs?..... | Yes | No |
| 39. | Has a doctor ever said you had heart trouble? | Yes | No |
| 40. | Does heart trouble run in your family? | Yes | No |
| <hr/> | | | |
| 41. | Have you lost more than half your teeth?..... | Yes | No |
| 42. | Are you troubled by bleeding gums? | Yes | No |

43.	Have you often had severe tooth aches?.....	Yes	No
44.	Is your tongue usually badly coated?.....	Yes	No
45.	Is your appetite always poor?.....	Yes	No
46.	Do you usually eat sweets or other foods between meals?.....	Yes	No
47.	Do you always gulp your food hurriedly?.....	Yes	No
48.	Do you often suffer from an upset stomach?.....	Yes	No
49.	Do you usually feel bloated after eating?.....	Yes	No
50.	Do you usually belch a lot after eating?.....	Yes	No
51.	Are you often sick at your stomach?.....	Yes	No
52.	Do you suffer from indigestion?.....	Yes	No
53.	Do severe pains in the stomach often cause you to double up?.....	Yes	No
54.	Do you suffer from constant stomach trouble?.....	Yes	No
55.	Does stomach trouble run in your family?.....	Yes	No
56.	Has a doctor ever said you had stomach ulcers?.....	Yes	No
57.	Do you suffer from frequent loose bowel movements?.....	Yes	No
58.	Have you ever had severe bloody diarrhea?.....	Yes	No
59.	Were you ever troubled with intestinal worms?.....	Yes	No
60.	Do you constantly suffer from bad constipation?.....	Yes	No
61.	Have you ever had piles (rectal hemorrhoids)?.....	Yes	No
62.	Have you ever had jaundice (yellow eyes and skin)?.....	Yes	No
63.	Have you ever had serious liver or gall bladder trouble?.....	Yes	No
64.	Are your joints often painfully swollen?.....	Yes	No
65.	Do your muscles and joints constantly feel stiff?.....	Yes	No
66.	Do you usually have severe pains in the arms or legs?.....	Yes	No
67.	Are you crippled with severe arthritis?.....	Yes	No
68.	Does arthritis run in your family?.....	Yes	No
69.	Do weak or painful feet make your life miserable?.....	Yes	No
70.	Do pains in the back make it hard for you to keep up with your work?.....	Yes	No
71.	Are you troubled with a serious bodily disability or deformity?.....	Yes	No
72.	Do you have sensitive skin?.....	Yes	No
73.	Does it take a long time for a cut to heal?.....	Yes	No
74.	Does your face often get badly flushed?.....	Yes	No
75.	Do you sweat a great deal, even in cold weather?.....	Yes	No
76.	Are you often bothered by severe itching?.....	Yes	No
77.	Does your skin often break out in a rash?.....	Yes	No
78.	Are you often troubled with boils?.....	Yes	No
79.	Do you suffer from frequent severe headaches?.....	Yes	No
80.	Does pressure or pain in the head often make life miserable?.....	Yes	No
81.	Are headaches common in your family?.....	Yes	No
82.	Do you have hot or cold spells?.....	Yes	No
83.	Do you often have spells of severe dizziness?.....	Yes	No
84.	Do you frequently feel faint?.....	Yes	No
85.	Have you fainted more than twice in your life?.....	Yes	No
86.	Do you have constant numbness or tingling in any part of your body?.....	Yes	No
87.	Was any part of your body paralyzed?.....	Yes	No
88.	Were you ever knocked unconscious?.....	Yes	No
89.	Have you at times had a twitching of the head, face or shoulders?.....	Yes	No
90.	Did you ever have a seizure or convulsion (epilepsy)?.....	Yes	No
91.	Has anyone in your family ever had seizures or convulsions (epilepsy)?.....	Yes	No
92.	Do you bite your nails?.....	Yes	No
93.	Are you troubled by stuttering or stammering?.....	Yes	No
94.	Are you a sleep walker?.....	Yes	No
95.	Are you a bed wetter?.....	Yes	No
96.	Were you a bed wetter between the ages of 8 to 14?.....	Yes	No

Women Only... Are you Pregnant? Yes No

97w.	Have your menstrual periods usually been painful?.....	Yes	No
98w.	Have you often felt weak or sick with your periods?.....	Yes	No
99w.	Have you often had to lie down when your periods came on?.....	Yes	No
100w.	Have you usually been tense or jumpy with your periods?.....	Yes	No
101w.	Have you ever had severe hot flashes or sweats?.....	Yes	No
102w.	Have you often been troubled with a vaginal discharge?.....	Yes	No

Men Only...

97m.	Have you ever had anything wrong with your genitals?.....	Yes	No
98m.	Are your genitals often painful or sore?.....	Yes	No
99m.	Have you ever had treatment for your genitals?.....	Yes	No
100m.	Has a doctor ever said you had a hernia (rupture)?.....	Yes	No
101m.	Have you ever passed blood while urinating?.....	Yes	No
102m.	Do you have trouble starting your stream when urinating?.....	Yes	No

103.	Do you have to get up every night and urinate?.....	Yes	No
104.	During the day, do you usually have to urinate frequently?.....	Yes	No
105.	Do you have severe burning when you urinate?.....	Yes	No
106.	Do you sometimes lose control of your bladder?.....	Yes	No
107.	Has a doctor ever said you had kidney or bladder disease?.....	Yes	No

108.	Are you often exhausted or fatigued?.....	Yes	No
109.	Does working tire you out completely?.....	Yes	No
110.	Do you usually get up tired or exhausted in the morning?.....	Yes	No
111.	Does every little effort wear you out?.....	Yes	No
112.	Are you constantly too tired and exhausted even to eat?.....	Yes	No
113.	Do you suffer form severe nervous exhaustion?.....	Yes	No
114.	Does nervous exhaustion run in your family?.....	Yes	No

115.	Are you frequently ill?.....	Yes	No
116.	Are you frequently confined to bed by illness?.....	Yes	No
117.	Are you always in poor health?.....	Yes	No
118.	Are you considered a sickly person?.....	Yes	No
119.	Do you come from a sickly family?.....	Yes	No
120.	Do severe pains and aches make it impossible for you to do your work?.....	Yes	No
121.	Do you wear yourself out worrying about work?.....	Yes	No
122.	Are you always ill and unhappy?.....	Yes	No
123.	Are you constantly made miserable by poor health?.....	Yes	No

124.	Did you ever have scarlet fever?.....	Yes	No
125.	As a child, did you have rheumatic fever, growing pains, or twitching of the limbs?.....	Yes	No
126.	Did you ever have malaria?.....	Yes	No
127.	Were you ever treated for severe anemia?.....	Yes	No
128.	Were you ever treated for venereal disease?.....	Yes	No
129.	Do you have diabetes?.....	Yes	No
130.	Did a doctor ever say you had a goiter in your neck?.....	Yes	No
131.	Did a doctor ever treat you for a tumor or cancer?.....	Yes	No
132.	Do you suffer from any chronic disease?.....	Yes	No
133.	Are you definitely underweight?.....	Yes	No
134.	Are you definitely overweight?.....	Yes	No
135.	Did a doctor ever say you had varicose veins (swollen veins) in your legs?.....	Yes	No
136.	Did you ever have a serious operation?.....	Yes	No
137.	Did you ever have a serious injury?.....	Yes	No
138.	Do you often have small accidents or injuries?.....	Yes	No

139.	Do you usually have difficulty falling asleep or staying asleep?.....	Yes	No
140.	Do you find it impossible to take a regular rest period each day?.....	Yes	No
141.	Do you find it difficult to exercise daily?.....	Yes	No

142.	Do you smoke more than 20 cigarettes a day?	Yes	No
143.	Do you drink more than six cups of coffee or tea a day?	Yes	No
144.	Do you usually take two or more alcoholic drinks a day?.....	Yes	No
145.	Do you sweat or tremble a lot during examinations or questioning?.....	Yes	No
146.	Do you get nervous and shaky when approached by a superior?	Yes	No
147.	Does your work fall to pieces when the boss or a superior is watching you?	Yes	No
148.	Does your thinking get completely mixed up when you have to do things quickly?	Yes	No
149.	Must you do things slowly to do them without mistakes?	Yes	No
150.	Do you always get directions and orders wrong?.....	Yes	No
151.	Are you anxious around unfamiliar people or places?	Yes	No
152.	Are you scared to be alone when there are no friends around you?.....	Yes	No
153.	Is it difficult for you to make up your mind?	Yes	No
154.	Do you always wish you had someone at your side to advise you?.....	Yes	No
155.	Are you considered a clumsy person?	Yes	No
156.	Does it bother you to eat anywhere except in your home?.....	Yes	No
157.	Do you feel alone and sad at a party?	Yes	No
158.	Do you usually feel unhappy and depressed?	Yes	No
159.	Do you often cry?.....	Yes	No
160.	Are you always miserable and blue?	Yes	No
161.	Does life look entirely hopeless?.....	Yes	No
162.	Do you often wish you were dead and away from it all?.....	Yes	No
163.	Does worrying continually get you down?	Yes	No
164.	Does worrying run in your family?	Yes	No
165.	Does every little thing get on your nerves and wear you out?	Yes	No
166.	Are you considered a nervous person?	Yes	No
167.	Does nervousness run in your family?	Yes	No
168.	Did you ever have a nervous breakdown?	Yes	No
169.	Did anyone in your family ever have a nervous breakdown?	Yes	No
170.	Were you ever a patient in a mental hospital?.....	Yes	No
171.	Was anyone in your family ever in a mental hospital?.....	Yes	No
172.	Are you extremely shy or sensitive?	Yes	No
173.	Do you have a shy or sensitive family?.....	Yes	No
174.	Are your feelings easily hurt?.....	Yes	No
175.	Does criticism always hurt you?	Yes	No
176.	Are you considered a touchy person?.....	Yes	No
177.	Do people usually misunderstand you?	Yes	No
178.	Is your guard up, even around friends?	Yes	No
179.	Do you always do things on sudden impulse?.....	Yes	No
180.	Are you easily upset or irritated?	Yes	No
181.	Do you go to pieces if you don't constantly control yourself?.....	Yes	No
182.	Do little annoyances get on your nerves and get you angry?	Yes	No
183.	Does it make you angry to have anyone tell you what to do?.....	Yes	No
184.	Do people often annoy and irritate you?.....	Yes	No
185.	Do you often flare up in anger if you can't have what you want right away?.....	Yes	No
186.	Do you often get in a violent rage?	Yes	No
187.	Do you often shake or tremble?	Yes	No
188.	Are you constantly keyed up or jittery?.....	Yes	No
189.	Do sudden noises make you jump or shake?	Yes	No
190.	Do you tremble or feel weak whenever someone shouts at you?.....	Yes	No
191.	Do you become scared at sudden movements or noises at night?	Yes	No
192.	Are you awakened out of your sleep by frightening dreams?	Yes	No
193.	Do frightening thoughts keep coming back in your mind?	Yes	No
194.	Do you often become frightened for no apparent reason?.....	Yes	No
195.	Do you often break out in a cold sweat?.....	Yes	No