

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____

Email: _____ Gender: M / F Marital Status: Married / Other / Single

Social Security #: _____ Date of Birth: _____

Student Status: Full Student / Part Student / Non-Student Employed Employer: _____

*Referred By: _____

Ethnicity: Hispanic or Latino / Other

Preferred Language: _____

Race: Asian / African Am. / Am. Indian or Alaskan Native /
Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____

Primary Care Physician: _____

Home: _____ Mobile: _____

Doctor's Phone: _____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

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

PRIMARY INSURANCE

SECONDARY INSURANCE

Name: _____

Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Other than Self:

Insured's Name: _____ Gender: M / F

Insured's Name: _____ Gender: M / F

Address: _____

Address: _____

City: _____ State: _____ Zip: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Phone: _____ Date of Birth: _____

Who is responsible for payment? Self / Other - (Relationship) _____

Other than Self:

Full Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____

PATIENT CASE HISTORY



HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____/____/____ **Describe how this began:** _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe) _____

For this CURRENT condition, have you:

• **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____

• **Had any previous Surgery or Interventions in this area?** (Describe) _____

• **Taken any Medications?** OTC / Prescriptions _____

• **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)



Medications:

Allergies to Medications: NONE (List) _____

Current Medications: NONE

(Already have a list? We can make a copy.) _____



Past Health History: (Please list any past...)

Surgeries – Date, Type, and Reason: NONE

Major Injuries/Traumas: NONE _____

Major Hospitalizations: NONE _____

Patient No: _____



Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)



Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

Habits:

Cigarettes – (#/day) _____

Alcohol – (amount/day) _____

Coffee/Tea – (cups/day) _____

Rec. Drugs (List) _____

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- Recent Weight Change
Fever
Fatigue
None in this Category

Musculoskeletal:

- Low Back Pain
Mid Back Pain
Neck Pain
Arm Problems
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
None in this Category

Neurological:

- Numbness or tingling sensations
Loss of Feeling
Dizziness or light headed
Frequent or Recurrent Headaches
Convulsions or seizures
Tremors
Stroke
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
None in this Category

Gastrointestinal:

- Loss of Appetite
Blood in Stool
Change in Bowel Movements
Painful Bowel Movements
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, Nose and Throat:

- Bleeding gums / mouth sores
Bad Breath or bad taste
Dental Problems
Swollen throat or voice change
Swollen glands in neck
Ringing in the ears
Ear - Ache/Ringing/Drainage
Sinus / Allergy problems
Nose Bleeds
Hearing Loss
Other:
None in this Category

Endocrine, Hematologic, and

Lymphatic:

- Thyroid problems
Diabetes
Excessive Thirst or urination
Cold Extremities
Heat or Cold intolerance
Change in hat or glove size
Dry skin
Glandular or hormone problem
Swollen Glands
Anemia
Easily Bruise or Bleed
Phlebitis
Transfusion
Immune system disorder
Other:
None in this Category

Skin and Breasts:

- Rash or Itching
Change in Skin Color
Change in hair or nails
Non-healing sores
Change of appearance of a mole
Breast Pain
Breast Lump
Breast Discharge
Other:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

- Infertility
Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

Blank lines for recording pregnancy outcomes and dates.

Comments:

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 to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature Date

Treating Doctor Signature Date

Patient No:

Siraguso Family Chiropractic
Dr. Frank P. Siraguso, D.C.

Notice of HIPAA Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and updated laws on 9/23/2013, 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 multiple health care providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certification. I have been informed by you and your notice of privacy practices prior to signing this consent. I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree with my requested restriction, but if you do agree you are bound to abide by such restrictions. I further authorize disclosure of all or any part of my patient's record to any person or part of the clinics charge including, and not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

Consent of professional Service and Release of Information

I hereby authorize and release the doctor and whoever he may designate as his assistants to administer treatment, physical examination, orthopedic and neurological evaluation, visual inspection, palpation, X-Ray studies, laboratory procedures, chiropractic care, or any clinic service that he deems necessary in my case. The undersigned also consents to observation of therapeutic or diagnostic procedures by staff personnel or medical personnel in training as permitted by the attending practitioner and allowed by clinic policy. Treatment procedures that may be used in your treatment include, but are not limited to, manipulative therapy, activator, joint mobilization, myofascial release, trigger point therapy, electrical therapy, intersegmental traction, muscle stretching, and any directional handouts. Cases will be managed with all due concern and with the evaluation of response to previous care provided. Home care instructions will be given as appropriate to enhance your treatment program. Compliance with the recommendations for the home care and follow up care is necessary for the resolution of your complaint. Because of modern techniques and equipment, examination and therapeutic procedures involve a very low risk of complication. Even though serious problems rarely occur with these procedures, risk must be recognized and considered. Any procedure that is intended to help may also do harm. While examination and therapeutic procedures used in this clinic are considered remarkably safe and effective, understand that occasionally there may be adverse reactions that occur. Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate our patients. These complications include but are not limited to pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, fracture, fainting, irregular heartbeat, heart attack, spinal cord damage, nausea, burns, soft tissue injury, stroke, dizziness, or weakness. A patient, in coming to Siraguso Family Chiropractic gives Dr. Frank P. Siraguso (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 of care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures that he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor. The doctor provides a specialized, non-duplicating healthcare service, Dr. Frank P. Siraguso 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 by a physician at Siraguso Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon request. No guarantee or warranty for a specific cure or result is implied by the acceptance of your case. All patients respond differently to the treatment procedure. Each case must be evaluated separately. If you do not fully understand the above or have questions about anything mentioned in this document, please do not sign it until these matters have been resolved with further discussion. I have read the above explanation of treatment and diagnostic procedures used in this clinic and have myself decided that it is in my best interest to submit to these procedures.

Clinical Summary Report (CCR) regarding HER

I understand that a clinical summary report is created after each visit for the purpose of HER and is available for my review. At this time, I am asking Siraguso Family Chiropractic to save these electronically for me and not print them out after each visit. I understand that these reports are available to be printed or emailed to me for review.

Assignment of benefits

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. 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 professional services rendered to me and will be immediately due and payable.

Print Patient Name: _____ Authorized Signature: _____

Relationship to patient (if not self): _____ Date: _____

Siraguso Family Chiropractic
7825 N Oak TRFY
Kansas City, MO 64118

Patient Name: _____ D.O.B.: _____ Date: _____

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.

AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: _____

Signature of Parent or Guardian: _____

Siraguso Family Chiropractic

7825 N Oak Trafficway
Kansas City, MO 64118
816-272-3580

Patient Name: _____ DOB: _____ Date: _____

Consent for Chiropractic Services

By reading below I have been made aware:

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms, etc.), often resulting in an audible pop or click sound.
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold.
3. That on occasion some temporary soreness and/or stiffness may occur; or less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment.
4. That the chiropractor had made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

Therefore by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and/or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and/or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____

Witness Signature: _____