CASE HISTORY

Name: _____ Age: _____ Date: _____ Case Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone:(H) _____(C)_____Fax: _____ E-mail:_____
Date of Birth: _____ Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children: _____
Occupation: _____ Employer: _____ Telephone (Work): _____Ext. ____
Insured's Name: _____ Phone: _____ Insured's Date of Birth:_____
Spouse's Name: _____ Spouse's Occupation: _____
Spouse's Employer: _____ Spouse's Telephone (Work): _____
Past Chiropractic Care: ❑ Yes ❑ No When? _____ Doctor's Name: _____
Results:_____ Referred by: _____
Insurance Company: _____ Telephone: _____
Social Security Number:_____ Driver's License Number:_____ State: _____
Spouse's Insurance Company:_____ Telephone: _____
Spouse's Social Security Number:_____ Spouse's Driver's License Number:_____
Emergency Contact:_____Relationship_____Contact Number_____

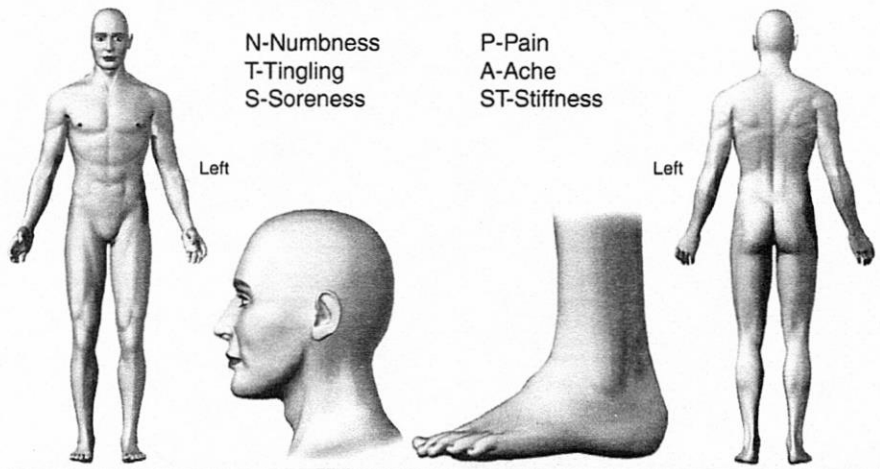
Are your present problems due to an injury? ❑ No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other: ___
Has the accident been reported? ❑ No ❑ Yes ❑ To Employer ❑ Auto Carrier ❑ Other: _____
Are you now or have you ever been disabled? (Service or Work)? ❑ No ❑ Yes When?_____ Why? _____
Have you retained an attorney? ❑ No ❑ Yes Name & Address: _____

Pain Symptoms: 1. _____ Began-(Mo/Yr): _____ Previous Episodes:_____
(in order of 2. _____ Began-(Mo/Yr): _____ Previous Episodes:_____
severity) 3. _____ Began-(Mo/Yr): _____ Previous Episodes:_____

Please mark the intensity of your pain today.
0 - NO PAIN
10 - INTENSE PAIN
Example _____Neck_____
O 1 2 3 ④ 5 6 7 8 9 10
1. _____
O 1 2 3 4 5 6 7 8 9 10
2. _____
O 1 2 3 4 5 6 7 8 9 10
3. _____
O 1 2 3 4 5 6 7 8 9 10

DOCTORS USE ONLY
_____
_____
_____
_____

Please mark area & type of pain on the drawings using the codes listed below.
N-Numbness P-Pain
T-Tingling A-Ache
S-Soreness ST-Stiffness



HABITS
❑ Smoking Packs/Day: _____
❑ Drinking Alcohol: _____
❑ Caffeine Cups/Day: _____

EXERCISE
❑ None
❑ Light Activity
❑ Moderate Activity
❑ Active
❑ Very Active
❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑ _____
Father	❑	❑	❑	❑	❑ _____
Brother,# of: ____	❑	❑	❑	❑	❑ _____
Sister,# of: ____	❑	❑	❑	❑	❑ _____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently.

Never	Previously	Presently	GENERAL SYMPTOMS	
❑	❑	❑	995.3	Allergy (What)___
				_____
❑	❑	❑	490	Bronchitis
❑	❑	❑	780.9	Chills
❑	❑	❑	780.39	Convulsions
❑	❑	❑	780.4	Dizziness
❑	❑	❑	780.2	Fainting
❑	❑	❑	780.79	Fatigue
❑	❑	❑	780.6	Fever
❑	❑	❑	784.0	Headache
❑	❑	❑	780.52	Loss of Sleep
❑	❑	❑	783	Loss of Weight
❑	❑	❑	799.2	Nervousness
❑	❑	❑	729.2	Neuralgia
❑	❑	❑	780.8	Sweats
❑	❑	❑	786.07	Wheezing
❑	❑	❑	311	Depression

Never	Previously	Presently	GASTRO-INTESTINAL	
❑	❑	❑	787.3	Belching/Gas/Bloating
❑	❑	❑	789.0	Abdominal Pain
❑	❑	❑	564.0	Constipation
❑	❑	❑	787.91	Diarrhea
❑	❑	❑	783.6	Excessive Eating
❑	❑	❑	575.9	Gall Bladder Trouble
❑	❑	❑	455	Hemorrhoids (piles)
❑	❑	❑	782.4	Jaundice
❑	❑	❑	794.8	Liver Trouble
❑	❑	❑	787.02	Nausea
❑	❑	❑	536.9	Stomach Pain
❑	❑	❑	783.0	Poor Appetite
❑	❑	❑	536.8	Poor Digestion
❑	❑	❑	787.03	Vomiting
❑	❑	❑	578.0	Vomiting Blood
❑	❑	❑	783.5	Excessive Thirst
❑	❑	❑	536.8	Indigestion
❑	❑	❑	569.3	Rectal Bleeding

Never	Previously	Presently	EYE/EAR/NOISE/THROAT	
❑	❑	❑	493.9	Asthma
❑	❑	❑	378.9	Crossed Eyes
❑	❑	❑	389.9	Deafness
❑	❑	❑	388.70	Earache
❑	❑	❑	388.60	Ear Discharge
❑	❑	❑	388.30	Ear Noises
❑	❑	❑	240.9	Enlarged Thyroid
❑	❑	❑	460	Frequent Colds
❑	❑	❑	477	Hay Fever
❑	❑	❑	784.49	Hoarseness
❑	❑	❑	478.1	Nasal Obstruction
❑	❑	❑	784.7	Nosebleeds
❑	❑	❑	379.91	Pain in Eyes
❑	❑	❑	368.9	Poor Vision
❑	❑	❑	461.9	Sinusitis
❑	❑	❑	462	Sore Throat
❑	❑	❑	463	Tonsillitis
❑	❑	❑	786.2	Persistent Cough
❑	❑	❑	787.2	Difficulty Swallowing
❑	❑	❑	523.8	Bleeding Gums

Never	Previously	Presently	RESPIRATORY	
❑	❑	❑	786.50	Chest Pain
❑	❑	❑	786.2	Chronic Cough
❑	❑	❑	786.09	Difficulty Breathing
❑	❑	❑	786.3	Spitting Blood
❑	❑	❑	786.4	Spitting Phlegm

GENITO-URINARY

❑	❑	❑	788.36	Bed Wetting
❑	❑	❑	599.7	Blood in Urine
❑	❑	❑	788.4	Frequent Urination
❑	❑	❑	788.3	Lack of Bladder Control
❑	❑	❑	590.9	Kidney Infection
❑	❑	❑	788.1	Painful Urination
❑	❑	❑	601.9	Prostate Trouble

			MUSCLES/JOINTS/BONES	
❑	❑	❑	724.5	Backache
❑	❑	❑	719.7	Foot Trouble
❑	❑	❑	550	Hernia
❑	❑	❑	719.1	Pain Between Shoulders
❑	❑	❑	724.6	Painful Tail Bone
❑	❑	❑	723.9	Stiff Neck
❑	❑	❑	781.9	Spinal Curvature
❑	❑	❑	719.0	Swollen Joints
❑	❑	❑	781.0	Tremors/Twitching
❑	❑	❑	782	Arm Trouble

			CARDIO-VASCULAR	
❑	❑	❑	401.9	High Blood Pressure
❑	❑	❑	458.9	Low Blood Pressure
❑	❑	❑	786.51	Pain Over Heart
❑	❑	❑	785.9	Poor Circulation
❑	❑	❑	438	Previous Heart Trouble
❑	❑	❑	785.0	Rapid Heart
❑	❑	❑	427.89	Slow Heart
❑	❑	❑	436	Strokes
❑	❑	❑	719.7	Swelling Ankles
❑	❑	❑	454	Varicose Veins

			SKIN OR ALLERGIES	
❑	❑	❑	680.9	Boils
❑	❑	❑	924.9	Bruising Easily
❑	❑	❑	701.1	Dryness
❑	❑	❑	691.8	Eczema
❑	❑	❑	708.9	Hives or Allergy
❑	❑	❑	698.9	Itching
❑	❑	❑	782.0	Sensitive Skin
❑	❑	❑	782.1	Skin Eruptions

			FOR WOMEN ONLY	
❑	❑	❑	625.3	Cramps or Backaches
❑	❑	❑	626.2	Excessive Flow
❑	❑	❑	627.2	Hot Flashes
❑	❑	❑	626.4	Irregular Cycle
❑	❑	❑	634.9	Miscarriage
❑	❑	❑	625.3	Painful Periods
❑	❑	❑	623.5	Vaginal Discharge
❑	❑	❑	611.79	Lump in Breast
❑ Yes	❑ No			Pregnant at this time?
❑ Yes	❑ No			Have you had a mammogram?
_____				Last Pap Smear Date
_____				By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other: _____	_____	Other: _____	_____	Other: _____

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car:_____ ❑ Recreation: _____
❑ Sports:_____ ❑ School:_____ ❑ Other:_____
List any broken bones (fractures) or dislocations: _____
Ever on crutches? ❑ Yes ❑ No Why?_____
Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No
Have you ever had a lapse of memory? ❑ Yes ❑ No
Have you ever had X-rays taken? ❑ Yes ❑ No When?_____ By Whom?_____
For what ailments were these X-rays made?_____
Do you suffer from any condition other than that for which you are now consulting us? _____
Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No What drugs?_____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____

DELANEY
FAMILY CHIROPRACTIC

Patient Name:	Date:

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

DELANEY
FAMILY CHIROPRACTIC

Patient Name:	**Date:**

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. If my insurance will be billed, I authorize payment of medical benefits to DeLaney Family Chiropractic for services performed.

To meet the needs of our patients, DeLaney Family Chiropractic participates in various insurances programs. Each carrier has its own specific guidelines regarding the patient's financial responsibility. While we will work with you and your insurance carrier to provide you with quality and compassionate care within the guidelines of your plan, we expect our patients to understand and acknowledge their financial responsibilities.

Please carefully review the following items:

- Payment for all services rendered is your financial responsibility
- If during our registration you provide us with your complete health insurance information, we will submit our charges to your insurance carrier for payment. You are responsible for all charges if you do not provide complete current accurate insurance information.
- If our practice is one of your network providers, you are responsible for paying your co-payments, deductibles, and coinsurance along with charges for non-covered items or services at the time of your appointment or when services are rendered.
- If our practice is non-network (*out-of-network*) provider, you are responsible for all charges.
- If Medicare is your primary insurance carrier and you have a valid secondary insurance on file with us, we will submit the 20% coinsurance not paid by Medicare to your secondary carrier. If Medicare is your only insurance carrier, you are responsible for the 20% coinsurance not paid by Medicare.
- All auto and workers' compensation patients are asked to provide their private health insurance, including any necessary referrals, in addition to your complete auto/workers' compensation billing information. In the event your auto/workers' compensation claim is denied, we will submit any charges incurred to your private health insurance carrier. If you private health insurance information is not on file you will be billed directly for all charges.
- As authorization is not a guarantee of payment, if your health insurance carrier(s) denies payment for charges submitted to them, we will bill you directly for those charges.

All patients are requested to sign an acknowledgement of their financial responsibility. In the event the patient chooses not to sign the acknowledgment of responsibilities, DeLaney Family Chiropractic reserves the right to withhold treatment.

By signing below, you agree to the terms and conditions above.

Patient or Representative Signature _____ Date_____

I _____give permission for the following person(s) to have access to my PHI (personal health information). You may share results and discuss my treatment with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Your Signature Date