INTRODUCTION PATIENT CASE HISTORY

Today's Date: ____/____/_____

PATIENT INFORMATION

Name: *(First MI Last)* ______________________________ **Preferred Name:** ______________

Address: ______________________________ **City:** ______________ **State:** _______ **Zip:** ______________

Date of Birth: ___________ **Gender:** ☐ Male ☐ Female **Social Security #:** ______________________

Home: _______________ **Mobile:** _______________ **Work:** ______________________

Email: ______________________________

Preferred Method of Contact: ☐ Text ☐ Email ☐ Home Phone ☐ Other: ___________

*Referred By: *(Name)* ______________________

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: ___________

Race & Ethnicity: *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaii or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _______________
- ☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* ______________________________ **Primary Care Physician:** ______________________

Home: _______________ **Mobile:** _______________ **Doctor's Phone:** ______________________

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: ______________

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: ___________

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: ______________________ *ID#:* _______________

Secondary: ______________________ *ID#:* _______________

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: ______________________________

Address: ______________________________

Phone: _______________ *Email:* ______________________

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

Account No: ___________

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SEAMLESS™EHR

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint: ______________________________

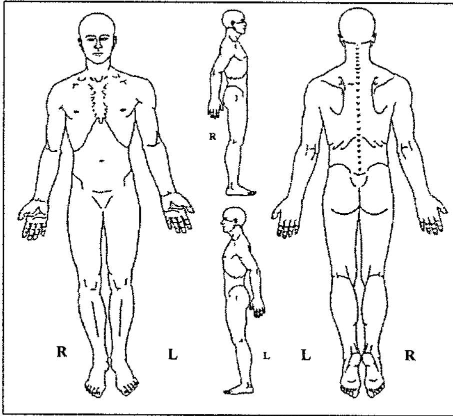
Secondary Complaints: ______________________________

When did it start? ___/___/____ **What happened?** ______________________________

Which daily activities are being affected by this condition? ______________________________

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm
T __ Tender
H __ Hypoesthesia

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: ____________

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: ____________
- ☐ Other: ____________

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: ____________

Previous Treatment:

- ☐ None
- ☐ Chiropractor ____________
- ☐ Medical Doctor ____________
- ☐ Physical Therapy ____________
- ☐ ER/Urgent Care ____________
- ☐ Orthopedic ____________
- ☐ Other: ____________

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays ____________
- ☐ MRI ____________
- ☐ CT ____________
- ☐ Other: ____________

*Women: *Are you pregnant?*

☐ No *Last Menstrual Period:* ___/___/___

☐ Yes *Due date:* ___/___/___

Present Illness Comments:

____

Prescription Medications & Supplements: ☐ None

☐ Yes *(List – Name, dosage, frequency)* ______________________________

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)* ______________________________

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Revision Date 03/01/2017

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) ________
- ☐ Blood Clots
- ☐ Cancer (*Type*) ____________________
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: ____________________

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: ____________________

Hospitalizations: *(Non-surgical with Date)*

Surgeries: *(If yes, provide type & surgery date)*

- ☐ Cancer ____________________
- ☐ Orthopedic
  - Shoulder – R / L __________
  - Elbow/Forearm – R / L __________
  - Wrist/Hand – R / L __________
  - Hip – R / L __________
  - Knee – R / L __________
  - Ankle/Foot – R / L __________
- ☐ Spinal Surgery
  - Neck: __________
  - Back: __________
- ☐ Other: ____________________

Medical History Comments:

FAMILY HISTORY *(Please mark X to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other:________________

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.

☐ Post Grad. ☐ Other: ____________________

Employed: ☐ No ☐ Yes (*Occupation*) ____________________

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* __________

☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:

☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:

☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:

☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: ____________________

REVIEW OF SYSTEMS

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: ____________________
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones ________________
- ☐ Other: ____________________
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: ____________________
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ____________________
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: ____________________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ____________________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: ____________________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: ________________
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: ____________________
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: ____________________
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: ____________________
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: ____________________
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: ____________________
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: ____________________
- ☐ *None in this Category*

Review of Systems Comments:

____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ____ Date ________________

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Revision Date 03/01/2017

Chiropractic Wellness Center PLLC
Dr Lance Hoose
2442 E 21st ST, Tulsa OK 74114
P (918)742-0560 F (918)742-0605

Health Insurance Portability & Accountability Act (HIPPA) 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 you're Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use 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, and also 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 of Disclosure of Your Information

You may request a restriction on the use of 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 (PHI) 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.

Clinical Summary Report (CCR) for EHR

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

Revocation of Consent (please check ONE box)

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use of 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: ______________

Chiropractic Wellness Center

Lance A. Hoose D.C.

ASSIGNMENT OF BENEFITS FOR INSURANCE PURPOSES

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 daily basis as 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 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.

I, ____________________________ (print) acknowledge, except and agree that I am responsible for my deductible and/or Co-payment if not covered by my insurance company.

Signature:____________________________________Date:____________________

Assignment and Conveyance of Lien Interest for Personal Injury Patients

I hereby execute and provide an 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 paid in the form of an insurance settlement(s), Claim(s) judgments, 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 Dr. Hoose/Chiropractic wellness Center 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 Dr Hoose/Chiropractic Wellness Center. In the event my insurance settlement proceeds are paid directly to my attorney and 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 Dr. Hoose/Chiropractic Wellness Center and remit payment for all such sums upon receipt of my settlement award(s)

Patient Signature: ______________________________________ Date:_________________

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: ______________________ Signature: ______________________ Date:

Parent or Guardian: ______________________ Signature: ______________________ Date:

Witness Name: ______________________ Signature: ______________________ Date: