CASE HISTORY

PATIENT INFORMATION: Marital Status : Single Married Divorced Widowed Sex: F M
Name: _____ Phone: _____ Cell: _____
Address: _____ City: _____ State: _____ Zip: _____
Birthday: ___/___/___ Social Security #: _____-_____-_____ Emergency Contact Name:_____ PH:_____
Employer: _____ Phone: _____
Medical Physician: _____ Phone: _____
Address: _____
How were you referred to our office? _____Friend/Relative (Name) _____
_____News article _____Radio/TV _____Phone book _____Other

PLEASE PROVIDE COMPLETE / ACCURATE INFORMATION!

Is your complaint related to a WORK or AUTO ACCIDENT? Y N (if yes please inform receptionist)
*** When did complaint start?** (*Insurance requires a date for plan coverage*)____/____/____
*** Your complaint is** : [ ] Neck pain [ ] Headache [ ] Middle back [ ] Low back pain [ ] Leg/Arm pain or tingling
Please describe your symptoms:
_____
*** What caused the complaint?** _____
Have you been treated for this complaint previously [N] [Y]. Who treated you? _____
Pain intensity is [ ] Mild [ ] Moderate [ ] Severe *** Are your symptoms:** [ ] Decreasing [ ] Not changing [ ] Increasing
Frequency of pain [ ] Constant [ ] Frequent [ ] Occasional [ ]Intermittent *** Pain is** [ ] Sharp [ ] Dull [ ] Achiness [ ] Throbbing
Symptoms are worse in the [ ] AM [ ] PM [ ] Increases during the day [ ] Same all day
What makes your complaint better? [ ]Nothing [ ]Lying down [ ]Walking [ ]Sitting [ ]Standing [ ]Movement [ ]Other_____
What makes your complaint worse? [ ]Nothing [ ]Lying down [ ]Walking [ ]Sitting [ ]Standing [ ]Movement [ ]Other_____

Have you ever been treated for or suspected of having Cancer past or present? Y N
List Surgeries and/or Accidents: _____
Is there any other health condition the doctor should know about? _____
Do you smoke? Y N Do you use alcohol? Y N
Were X-Rays or other testing done? Y N IF YES WHAT TESTS?_____
Where / When? _____

PLEASE CIRCLE SYMPTOMS THAT YOU EXPERIENCE OFTEN OR ARE EXPERIENCING CURRENTLY:

GENERAL
Weight change
Fever
Chills
Sweats
Allergies
Anemia
Bruising

GASTROINTESTINAL SYSTEM
Nausea
Vomiting
Diarrhea
Heartburn
Indigestion
Constipation
Ulcer
Liver Disease
Pancreatitis
Blood in Stool
Gallbladder Disease

ENDOCRINE SYSTEM
Thyroid Problems
Diabetes
Neck Surgery

CARDIOVASCULAR SYSTEM
Chest Discomfort
Heart Disease
Palpitations
High Blood Pressure

NEUROLOGICAL SYSTEM
Headaches
Seizures
Stroke
Fainting
Weakness
Head Trauma
Dizziness
Ringing in ears

Does your family history include?
High Blood Pressure
Alzheimer Disease
Parkinson Disease
Kidney Disease
Thyroid Disease
Heart Disease
Diabetes
Cancer
Stroke

GENITOURINARY SYSTEM
Kidney Disease
Flank Pain
Painful Urination
Urinary Tract Infection

MUSCULOSKETAL SYSTEM
Low Back Pain
Leg Pain
Neck Pain
Arm Pain
Joint Stiffness
Joint Swelling

HOSPITALIZATIONS & MEDICATIONS
Y N Anxiety
Y N Depression
Y N Psychiatric Hospitalization
Y N Supplements
Y N Medications list below:
_____
_____
_____
_____

Patient Signature: _____ Date: _____

INFORMED CONSENT

Chiropractic, as with other types of health care, is associated with potential risks in the delivery or application of treatment. Therefore, it is necessary to inform the patient of such risks. While Chiropractic treatment is remarkably safe, you need to be informed about potential risks, no matter how remote, related to your care to allow you to be fully informed in consenting treatment. Some patients may experience soreness after an adjustment and in extremely rare instances soft tissue, rib injury or physical therapy burns may occur. A very small risk of stroke has been associated with upper cervical treatment but is extremely rare. Every patient is evaluated and treated individually. Should you have any questions regarding potential risks, Dr. Brydges and/ or Dr. Skowronek will be happy to address your concerns.

Notice of Financial Responsibility

I understand that I may be financially responsible for charges incurred at this office, including co-pay, co–insurance, deductibles and charges not covered by my insurance policy. This can include any visits not deemed as medically necessary by my insurance policy; such as for chronic conditions, preventative and maintenance visits.

ASSIGNMENT OF INSURANCE BENEFITS

I, The undersigned have insurance coverage with:

_____

(NAME OF YOUR INSURANCE)

And assign directly to DR. KEVIN J SKOWRONEK all medical benefits. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

I have read the above statements.

Patient Signature: _____ Date: _____

INSURANCE CARRIER INFORMATION

Please provide us with any new ID cards, if applicable.

Insurance Co. _____ID # _____
Insurance Co. _____ID# _____
Policy Holder _____DOB _____
Relationship to policy holder? [ ] Self [ ] Spouse [ ] Child [ ] Other _____