INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

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

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

Mobile: _____ **Home:** _____ **Work:** _____

Email: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Non-Binary

Marital Status: ☐ Single ☐ Married ☐Divorced ☐Other

Employed: ☐No ☐ Yes ☐ Retired

Occupation: _____ **Employer:** _____

*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 Hawaiian 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: _____

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

HISTORY OF PRESENT ILLNESS

Date:_____

HISTORY OF PRESENT ILLNESS *(Please describe)*

Major Complaint:

Secondary Complaints:

When did it start?: _____

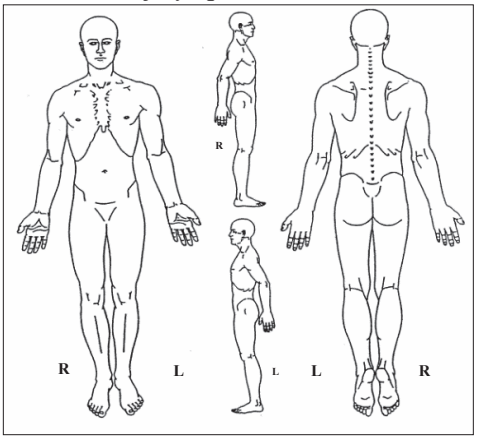
What happened?:

Which daily activities are being affected by this condition?:

MAJOR COMPLAINT

Please mark

Location of Symptoms and Radiation



Does it radiate?

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

Frequency:

☐ Off & On

☐ Constant

Quality:

☐ Sharp

☐ Stabbing

☐ Burning

☐ Achy

☐ Dull

☐ Stiff & Sore

☐ Other: _____

Since the onset: *Is it...?*

☐ Better

☐ Same

☐ Worse

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)

Improves with:

☐ Ice

☐ Heat

☐ Movement

☐ Stretching

☐ OTC Medications: _____

☐ Other: _____

Worsens with:

☐ Sitting

☐ Standing/Walking

☐ Lying Down/Sleeping

☐ Overuse/Lifting

☐ Other: _____

Have you had past episodes?

☐ Yes

☐ No

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:* ___/___/____

Prescription Medications & Supplements: ☐ None

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

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)*

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

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: _____

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 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_____

Whole Body Chiropractic - Sherman - 517 N. Travis Street, Sherman, TX 75090
P: (903)-328-6185 F: (903)-357-5112

David Bynum, D.C. | Brent D. Money, D.C. | Cody Academia, D.C. | Troy Sebo, D.C.
Isabel Ramirez, D.C. | Aaron Sarkon, D.C. | Abigail Parris, D.C. | Hannah Bahn, D.C. | Lauren Academia, D.C.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

Your Protected Health Information (PHI) 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 PHI 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 PHI. 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/her 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.

Revocation of Consent
You may revoke this consent to the use and disclosure of your PHI. 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 Personal Health Information (PHI) in accordance with the Privacy Practices.

☐ I, _____(print) acknowledge that I have reviewed the above information and DO NOT give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used within the office for purposes of my care, to those individuals designated by the doctor. (YOU CANNOT CHOOSE THIS OPTION IF YOU ARE USING INSURANCE)

Patient Signature: X_____ Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien
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. In the event that your insurance company does not pay in a timely manner, 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 of Rights and Conveyance of Lien Interest
I hereby execute and provide Irrevocable Lien Interest and Assignment of Proceeds to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request. To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.
I instruct checks to be made payable to Whole Body Chiropractic - Sherman, and payment to be sent to 517 N. Travis Street, Sherman, TX 75090.
This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. 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 and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Patient Signature: X_____ Date: _____

Informed Consent for Treatment

David Bynum, D.C. | Brent D. Money, D.C. | Cody Academia, D.C. | Troy Sebo, D.C.
Isabel Ramirez, D.C. | Aaron Sarkon, D.C. | Abigail Parris, D.C. | Hannah Bahn, D.C. | Lauren Academia, D.C.

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

Patient Signature: X_____ Date: _____

Parental Consent for Minor Patient

Patient Name: _____ Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for Patient: _____

Signature: _____ Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____

Signature: _____ Relationship to Patient: _____

Functional Rating Index

For use with Neck and/or Back Problems

In order to accurately assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely describes your condition right now.

1. Pain Intensity

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Need To Go Slowly	Moderate Pain; Need Some Assistance	Severe Pain; need 100% Assistance

4. Travel (driving, etc.)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Can Do Usual Work Plus Unlimited Extra Work	Can Do Usual Work; No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Frequency of Pain

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No Pain	Occasional Pain; 25% of the day	Intermittent Pain; 50% of the day	Frequent Pain; 75% of the day	Constant Pain; 100% of the day

8. Lifting

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No Pain; Any Distance	Increased Pain After 1 Mile	Increased Pain After 1/2 Mile	Increased Pain After 1/4 Mile	Increased Pain With All Walking

10. Standing

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After 1/2 Hour	Increased Pain With Any Standing

Name: _____ Date: _____

Signature: _____ Score:_____/40 Percentage:_____%