

# Patient Case History & Information

Date: \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Best Way to Reach You? \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: M F Race: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Who is responsible for the account (minors only): \_\_\_\_\_

Address for the Acct. Responsible (minors only): \_\_\_\_\_

In Case of Emergency: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Medical Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

## HISTORY OF PRESENT CONDITION:

Chief Complaint- Purpose of this appointment: \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Is this due to: Auto \_\_\_ Work \_\_\_ Other \_\_\_\_\_ Days lost from work: \_\_\_\_\_

Have you ever had the same or a similar condition?  $\pi$  Yes  $\pi$  No If yes, when and describe: \_\_\_\_\_

## PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from?

(Place a check mark by conditions that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Ulcers

Do you have a history of stroke or hypertension? \_\_\_\_\_

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_

Has a physician treated you for any health condition in the last year?  $\pi$  Yes  $\pi$  No

If yes, describe: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Do you have any allergies to any medications?  $\pi$  Yes  $\pi$  No

If yes, describe: \_\_\_\_\_

Do you have any allergies of any kind?  $\pi$  Yes  $\pi$  No

If yes, describe: \_\_\_\_\_

Questions/Concerns you may have about your care:

Rank from Greatest (4) to Least (1)

Time constraint/My Busy Schedule  
 The Chiropractic Adjustment  
 Financial Concerns  
 How Long My Care Will Take  
 I have no Questions/Concerns

Please list any other health problems you have, no matter how insignificant they may be:

**SOCIAL HISTORY:**

Do you drink alcoholic beverages? \_\_\_ If so, how much per week? \_\_\_\_\_  
Do you use any tobacco products? \_\_\_\_\_ Do you smoke? \_\_\_ If so, packs per day: \_\_\_\_\_  
Do you take vitamin supplements? \_\_\_\_\_ If so, please list: \_\_\_\_\_  
Do you consume caffeine? \_\_\_ If so, how much per day: \_\_\_\_\_  
Do you exercise? \_\_\_\_\_ If yes, what is the frequency and type of exercise? \_\_\_\_\_  
What are your hobbies? \_\_\_\_\_  
What percentage of time during the day (at home or at your job away from home) do you spend:  
lifting \_\_\_ sitting \_\_\_ bending \_\_\_ working at a computer \_\_\_\_\_

**FAMILY HISTORY:**

Parents:  
Father: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased:  
Mother: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased:  
Check if applicable to you: \_\_\_\_\_ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:  
\_\_\_\_\_

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis \_\_\_\_\_ Cancer \_\_\_\_\_ Mental Illness \_\_\_\_\_  
Diabetes \_\_\_\_\_ Asthma \_\_\_\_\_ Heart Disease \_\_\_\_\_  
Stroke \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Lung Disease \_\_\_\_\_  
Arthritis \_\_\_\_\_ Liver Disease \_\_\_\_\_  
Other \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case:  
π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident  
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Name of Secondary Insurance Company (if any): \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

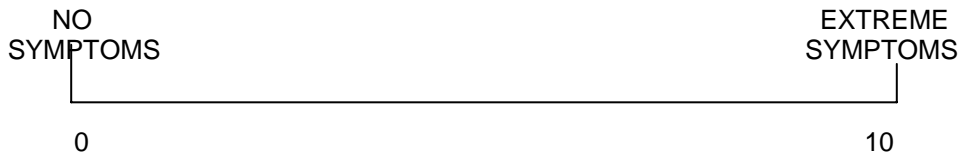
Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Acct.#: \_\_\_\_\_

Patient Summary

1. What is your major symptom? \_\_\_\_\_
2. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_  
How did it originally occur? \_\_\_\_\_  
Has it become worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually Worse \_\_\_  
If yes, when and how? \_\_\_\_\_
3. How frequent is the condition? Constant \_\_\_ Daily \_\_\_ Intermittent \_\_\_ Night Only \_\_\_  
How long does it last? All Day \_\_\_ Few Hours \_\_\_ Minutes \_\_\_
4. Are there any other conditions or symptoms that may be related to your major symptom?  
Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_  
Are there other unrelated health problems? Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_
5. Describe the pain: Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_  
Burning \_\_\_ Stabbing \_\_\_ Other \_\_\_\_\_
6. Is there anything you can do to relieve the problem? Yes \_\_\_ No \_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_. If no, what have you tried to do that has not helped? \_\_\_\_\_  
\_\_\_\_\_
7. What makes the problem worse? Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending \_\_\_  
Lifting \_\_\_ Twisting \_\_\_ Other \_\_\_\_\_
8. Have you had any broken bones? Yes \_\_\_ No \_\_\_. If yes, please list and give dates \_\_\_\_\_  
\_\_\_\_\_
9. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_  
\_\_\_\_\_
10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes \_\_\_ No \_\_\_. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  
Yes \_\_\_ No \_\_\_ Uncertain \_\_\_
12. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Please place an "X" on the line above to indicate your level of problem.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Initials \_\_\_\_\_ Date \_\_\_\_\_

Additional History



## Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Finn Chiropractic Group** to disclose certain protected health information (PHI) about me for the following purposes only (please read and check boxes):

- Confirmation calls for appointments
- Email reminders for upcoming events
- Newsletter via email
- Other \_\_\_\_\_

Signature:

---

My signature below acknowledges that I have been offered to receive a copy of the Practice's Privacy Notice that has an effective date of April 3, 2003.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Finn Chiropractic, 536 Northpointe Circle, Seven Fields, PA 16046

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian      Date      Relationship to Patient

\_\_\_\_\_  
Print Patient's Name      Print Name of Legal Guardian if applicable

# Finn Chiropractic Patient Policies

1. **Your Treatment-** Please follow the treatment plan prescribed to you by Dr. Finn. Your plan is based on your condition and our ability to treat that condition. If you wish to achieve optimal results, you will need to come to your visits, perform your exercises and do your home care. We will give you 110%. We expect the same effort from our patients. **If your condition would change, please alert the front desk staff so that Dr. Finn and Dr. Pasierb can properly examine your condition.**

2. **Appointments-** We respect the busy lives of our patients and we give our best to honor their appointments with punctuality. We ask that our patients have that same respect for our schedule. We respectfully ask that you come to your appointments on time and that if you need to cancel your appointment, please do so 24 hours prior to that appointment time. We do understand that things come up from time to time with family and work. We understand that short notice cancellations will occur. We simply ask that they do not become habitual.

3. **Cell Phone Usage-** We ask that you refrain from cell phone use after leaving the front reception area. Cell phone use can have a negative effect on our therapy machines and they disturb the relaxed atmosphere of our facility. Please turn your phone off. Thank you.

4. **Financial Services-** If you have any changes to your insurance during your treatment, it is imperative that you alert the front staff. We always want to know what is covered under your plan as it helps to eliminate billing mishaps. We ask that each patient make payment upon receiving services. Financial arrangements may also be made with our Billing Department.

Thank you for choosing Finn Chiropractic for your healthcare needs. Our goal is to exceed all of your expectations, both on a healthcare and customer service basis. In order to do this, we ask you to please be compliant with the above policies.

It is our primary goal to make sure that you have an extraordinary experience at our facility. We feel very passionate about the positive impact that chiropractic care will have on your life. We depend on our patients to spread the word about our commitment to their care. Please, tell your family and friends about your experience and encourage them to use our facility when they need us. We truly appreciate your referrals!

Patient Signature      Date

# How did you hear about us?

How did you hear about our office?

Please circle one and provide additional information as requested. Thank you.

1. **Family/Friend/Co-worker**

Name: \_\_\_\_\_

2. **Advertisement**

Publication: \_\_\_\_\_

3. **Building Sign**

4. **Insurance Plan**

a. **Book**

b. **Online**

5. **Physician Referral**

Dr's Name: \_\_\_\_\_

6. **Internet Search**

7. **Active Release Technique (ART) Website**

8. **Speaking Engagement/ Outreach Even**

Name of Event: \_\_\_\_\_

9. **Yellow Pages**

## NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

### Please read carefully:

*This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only **ONE CHOICE** which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just **mark the one box which most closely describes your problem right now.***

#### SECTION 1 – Pain Intensity

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

#### SECTION 2 – Personal Care (washing, dressing, etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help every day in most aspects of self care.
- F. I do not get dressed, wash with difficulty and stay in bed.

#### SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives extra pain.
- C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

#### SECTION 4 – Reading

- A. I can read as much as I want with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I can hardly read at all because of severe pain in my neck.
- F. I cannot read at all.

#### SECTION 5 – Headaches

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

#### SECTION 6 – Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

#### SECTION 7 – Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

#### SECTION 8 – Driving

- A. I can drive without any neck pain.
- B. I can drive as long as I want with slight pain in my neck.
- C. I can drive as long as I want with moderate pain in my neck.
- D. I cannot drive as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

#### SECTION 9 – Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hr. sleepless).
- C. My sleep is mildly disturbed (1-2 hrs. sleepless).
- D. My sleep is moderately disturbed (2-3 hrs. sleepless).
- E. My sleep is greatly disturbed (3-5 hrs. sleepless).
- F. My sleep is completely disturbed (5-7 hrs. sleepless).

#### SECTION 10 – Recreation

- A. I am able to engage in all my recreation activities with no neck pain at all.
- B. I am able to engage in all my recreation activities with some pain in my neck.
- C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
- E. I can hardly do any recreation activities because of pain in my neck.
- F. I cannot do any recreation activities at all.

#### OTHER COMMENTS:

---

---

---

Examiner \_\_\_\_\_