FIRST CHIROPRACTIC CENTER

# CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Age _____ Sex ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Home Phone _____ Work _____

Cell _____ E-Mail _____ Marital Status: ☐ M ☐ S ☐ D ☐ W

Occupation _____ Employer _____

Children, Ages _____ Spouse's Name _____

Who referred you to us? _____ How else did you hear about us? _____

What is your major concern? _____

_____

What do you think caused this condition? _____

How long have you had this condition? What date did it begin? _____

Have you had this or similar conditions in the past? _____

What positions or activities make it feel worse? _____

What positions or activities make it feel better? _____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

Other doctors or therapists who have treated THIS condition _____

For THIS condition, I have had: ☐ X-rays ☐ MRI ☐ CT Scan ☐ Other

Do you have a family physician? Name _____

List surgical operations and years: _____

_____

Have you been to a chiropractor before? _____ When was your last visit? _____

Current medical conditions, medications, dosage and frequency: _____

_____

_____

Signature _____ Date _____

Parent/Guardian _____ Date _____

Patient Name _____ Date _____

# CHILDREN'S EXAMINATION: KE

*NAME:* _____
*EXAMINER:* _____
*DATE:* _____

DATE OF BIRTH: _____ AGE: _____

SEX: _____

**BIRTH HISTORY:**

Delivery: ❑ Natural ❑ Drug-induced ❑ Drug-assisted ❑ C-section-Planned ❑ C-section-Emergency

Labor: ❑ < 3 Hrs. (precipitous) ❑ 3-6 Hrs. ❑ 6-15 Hrs. ❑ > 15 Hrs. (prolonged)

Complications: ❑ Abnormal Birth Position ❑ Forceps Used ❑ Spinal Anesthesia ❑ Vacuum Extractor

**EARLY CHILDHOOD HISTORY:**

Colic: _____ Recurrent Ear Infections: _____

Falls: _____ Crying, Irratibility: _____

Accidents: _____

Surgery: _____

Other: _____

**RECENT HEALTH HISTORY:**

Falls: _____ Muscular Development: _____

Accidents: _____ Coordination: _____

Surgery: _____

Complaints: _____

_____

Behavior At Home: _____

School Performance: _____

**EXAMINATION FINDINGS:**

Height: _____ Weight: _____

Adam's Test: Positive ❑ Negative ❑

Leg Length: Right _____ Left _____

Inversion Test: Head Rotation Right ❑ Left ❑

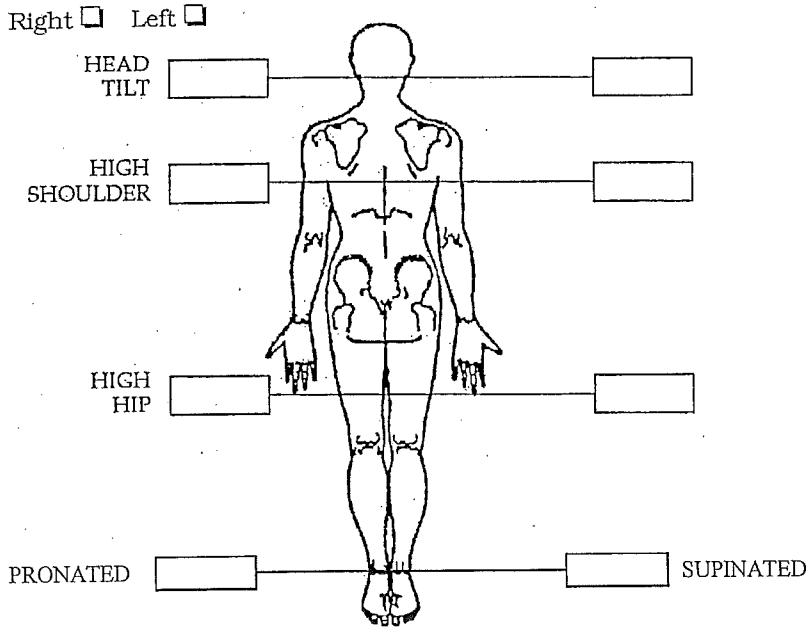
**MOTION PALPATION:**

C 1 2 3 4 5 6 7

T 1 2 3 4 5 6 7 8 9 10 11 12

L 1 2 3 4 5 SI R L

**POSTURAL ANALYSIS:**




**RECOMMENDATIONS:**

❑ Additional Examination Required ❑ Radiographic Examination Required

❑ Chiropractic Care: _____ Visits _____ Weeks

❑ Physical Therapy: _____ Visits _____ Weeks

❑ Foot Levelers Orthotics

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## Consent for Treatment

I, the undersigned, a patient of Dakota Chiropractic Clinics, P.C. hereby authorize Doctor(s) Thomas D. Stotz, James C. Fitzgerald, Sheila K. Fitzgerald, Thomas J. Stotz and whomever he/she designates as his/her assistant(s) to administer treatment as necessary. I also certify that no guarantee or assurance has been made as the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Dakota Chiropractic Clinics, P.C. will prepare any reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

X Patient's Signature_____Date_____Witness_____

## Authorization to Release Medical Information

I authorize the release of any medical information necessary to process insurance claim(s) and also certify that all insurance information given to Dakota Chiropractic Clinics, P.C. is correct and complete.

X Patient's Signature_____Date_____Witness_____

## Request for Payment of Benefits to Provider of Care

I hereby authorize my insurance company or administrator to pay Dakota Chiropractic Clinics, P.C. directly for the benefits otherwise payable to me under my current policy and that any balance due is my responsibility and agree to pay said balance in a timely manner. I agree that Dakota Chiropractic Clinics, P.C. be given power of attorney to endorse my name on any and all drafts for payment of my bill.

X Patient's Signature_____Date_____Witness_____

## Consent of Treatment of Minor

I hereby authorize Doctor(s) Thomas D. Stotz, James C. Fitzgerald, Sheila K. Fitzgerald, Thomas J. Stotz and whomever he/she may designate as his/her assistant to administer chiropractic health care as he/she deems necessary to this child.

Name of Child _____Relationship to Child_____

X Signature of Parent or Guardian_____Date_____Witness_____

Print Name of Parents/Guardians_____

## Consent to be X-Rayed

I hereby authorize Dakota Chiropractic Clinics, P.C. to perform radiographic examination on me. I realize that I will be exposed to X-ray radiation for this examination. I understand that the amount of exposure is usual and customary for my particular examination and that radiation will be kept to the least amount possible by the use of a shield, apron, and/or collimator.

X Patient's Signature_____Date_____Witness_____

Females only
I certify that to the best of my knowledge I am not currently pregnant._____

# OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $200 at any time. Our payment plans make care an affordable part of your family budget.

2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. These balances may not exceed $200. Our payment plans make care an affordable part of your family budget.

   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance. We accept credit cards and have payment plans available.

   If you discontinue care for any reason other than discharge by the doctor, all personal balances will become immediately due and payable in full by you, regardless of any claim submitted.

X Patient's Printed Name: _____

X Signature: _____ Date: _____

Finance Counselor: _____ Date: _____

Front Desk: _____ Date: _____

I acknowledge that I have been presented Dakota Chiropractic Clinics, P. C. Notice of Privacy Practices.

X _____ _____
Signature Date