CASE HISTORY – Fairview Chiropractic Center

421 Fairview Rd. Ellenwood GA 30294 (770) 389-1901

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Telephone (home)_____ (work)_____ (cell)_____

Social Security #_____ Age_____ Birthdate_____ Sex____ Status M S W D # Children_____

Occupation_____ Employer_____ Years Employed_____

Employer's Address_____ Email address_____

Spouse's Name_____ Occupation_____ Employer_____

Person responsible for this account_____ Referred by_____

WHAT IS YOUR MAJOR COMPLAINT?_____

Other complaints_____

How long have you had this condition?_____ Have you had similar conditions in the past? _____

What activities aggravate your condition?_____

Is this condition getting progressively worse? Yes_____ No_____ Constant_____ Comes and goes_____

How long has it been since you really felt good?_____

List surgical operations_____

Are you taking any prescription/non-prescription drugs?_____ What kind?_____

OTHER DOCTORS SEEN FOR THIS CONDITION: Dr._____ MD_ DC_ DO_ DDS_ Diagnosis_____

X-rays taken? Y N Urinalysis Y N Blood tests Y N Other_____

Treatment: Medication_____ Physiotherapy_____

Results_____ Length of time under care_____

Were you off work?_____ If so, how long?_____ Have you returned to the same job?____ If not, why?_____

_____

ACCIDENT INFORMATION

Did your accident occur while at work? Y N Were you involved in an automobile accident? Y N

Date_____ Time_____ Injury reported to employer Y N Name of Supervisor_____

Description of Accident_____

_____

Were you injured?_____ How?_____

Were you unconscious?_____ Fractures_____ Cuts_____ Abrasions_____ Bruises_____

Location_____ Patient taken to_____ Hospital for _____ treatment

confined to hospital for _____ Days_____ Hours_____ Name of hospital doctor_____

Have you had any other personal injury or accidents? Past year Y N Past 5 years Y N Over 5 years Y N None Y N

Describe_____

Attorney name/phone/address:_____

_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If my account becomes more than 30 days delinquent, I may be held liable for a delinquency fee of 1-1/2 % of the declining balance each month until the account is paid in full. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature_____ Date_____

FAIRVIEW CHIROPRACTIC CENTER 421 FAIRVIEW RD ELLENWOOD GA 30294

Check all symptoms that apply:

HEAD:
- Headache
  - sinus (allergy)
  - entire head
  - back of head
  - forehead
  - temples
  - migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

NECK:
- Pain in neck
- Neck pain with movement
  - Forward
  - Backward
  - Turn to left
  - Turn to right
  - Bend to left
  - Bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

SHOULDERS:
- Pain in shoulder joint (R-L)
- Pain across shoulder
- Bursitis (R-L)
- Arthritis (R-L)
- Can't raise arm
  - above shoulder level
  - over head
- Tension in shoulders
- Pinched nerve in shoulder (R-L)
- Muscle spasms in shoulder

ARMS & HANDS:
- Pain in upper arm
- Pain in elbow
- Movement aggravated
- Tennis elbow
- Pain in forearm
- Pain in hands
- Pain in fingers
- Sensation of pins & needles in arms
- Sensation of pins & needles in fingers
- Numbness in arms (R-L)
- Numbness in fingers (R-L)

ARMS & HANDS:
- Fingers go to sleep
- Hands cold
- Swollen joints in finger
- Arthritis in fingers
- Loss of grip strength

Feet feel cold

MID-BACK
- Mid-back pain
- Location_____
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasm
- Pain in kidney area

CHEST
- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN
- Nervous stomach
- Foods can't eat_____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:
- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroiliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when_____
- Slipped disk
- Low back feels out of place
- Muscle spasm
- Arthritis

HIPS, LEGS & FEET
- Pain in buttocks (R-L)
- Pain in hip joint (R-L)
- Pain down leg (R-L)
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet (R – L)
- Pins & needles in legs (R-L)
- Numbness of leg (R-L)
- Numbness of feet (R- L)
- Numbness of toes
- Swollen ankles (R-L)
- Swollen feet (R-L)

WOMEN ONLY
- menstrual pain_____
- Cramping
- Irregularity
- Cycle____ days
- Birth control _____type
- Hysterectomy
- Genital Cancer_____
- Discharge
- Color_____
- Tumors
- Abortions
- Menopause

MEN ONLY:
- urinary frequency
- Difficulty in starting
- Night urination
- Prostate pain/swelling

GENERAL
- Nervousness
- Irritable
- Depressed
- Fatigue

Generally fell run down
- Normal sleep_____
- Loss of sleep ____ hrs/nt
- Loss of weight ____ lbs
- Gain weight ____lbs
- Coffee ____cups/dy
- Tea ____ cups/dy
- Cigarettes ____ pack/dy
- Other _____
- Diabetes
- Hypoglycemia

AUTHORIZATIONS AND RELEASES – Fairview Chiropractic Center

Name:_____Patient #_____

Consent for Treatment

I, the undersigned authorize Dr. Carol Cozier-Douglas and whomever he may designate as his assistant to perform diagnostic tests, including but not limited to radiographs, and to administer treatment, as necessary.

I, also, certify that no guarantee or assurance has been made to 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. Furthermore, I understand that this office will prepare any necessary 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 remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature_____ Date_____ Witness_____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature_____ Date_____ Witness_____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Fairview Chiropractic Center, 421 Fairview Rd., Ellenwood GA 30294: the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given limited power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature_____ Date_____ Witness_____

Consent and Authorization to Perform X-Rays

I, the undersigned patient, have been informed by Dr. Carol Cozier-Douglas, that diagnostic x-rays are advisable in my case. X-rays are needed so that a complete analysis can be made of my present musculoskeletal problem (or illness). I authorize Dr. Carol Cozier-Douglas to perform such radiographic examinations necessary to diagnose my present condition or illness and to then administer whatever treatment Dr. Cozier-Douglas deems necessary. ***If female, to the best of my knowledge, I am NOT pregnant and Dr. Cozier-Douglas has my permission to X-ray me for diagnostic interpretation.

Patient's Signature_____ Date_____ Witness_____

Consent for Treatment of Minor

I hereby authorize Dr. Carol Cozier-Douglas and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (indicate relationship of child)

Child's name:_____

Guardian's Signature_____ Date_____ Witness_____

X-Ray / Medical Records Release

I have requested the release of records of (patient's name) _____
Which are a part of the records of Fairview Chiropractic Center.

I hereby request and authorize you, your employees and agents to furnish to the person listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to Fairview Chiropractic Center, 421 Fairview Rd., Ellenwood GA 30294.

Patient's Signature_____ Date_____ Witness_____

Fairview Chiropractic Center, Inc.
421 Fairview Rd., Ellenwood GA 30294
(770) 389-1901

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ , hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
    a. A postcard mailed to me at the address provided by me; and
    b. Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all ***future*** transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative* Relationship

Date Signed ____/____/____ Witness: _____

*Attorney-In-Fact, Guardian, Parent if a minor