

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? Yes 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? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes 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 **F**ather, **M**other, **S**ister, **B**rother):

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

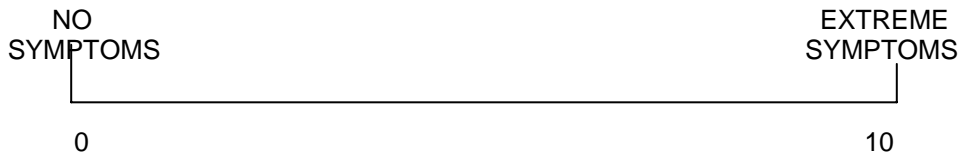
1. What is your major symptom? _____
2. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
3. How frequent is the condition? 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**

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____

Date _____

Please read carefully:

*This questionnaire has been designed to enable us to understand how your back 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. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

SECTION 4 – Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a stick or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me sitting more than 1 hour.
- D. Pain prevents me sitting more than ½ hour.
- E. Pain prevents me sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

OTHER COMMENTS:

SECTION 6 – Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than 1 hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Examiner