

CONFIDENTIAL PATIENT CASE HISTORY

ALL OTHER INSURANCE/CASH

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

Today's Date

/ /

Signature of Patient

Signature of Parent/Spouse/Guardian

Patient Title: (check one)

- Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name

Nick Name

Last Name

Middle Name

Suffix

Address 1

Address 2

City

State

Zip Code

Primary Phone

Secondary Phone

Mobile Phone

Home Email

Work Email

Which email address would you like us to use to communicate with you?

(Check one)

- Home Work

Contact Method (Check one)

- Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth

/

Age

Gender (Check one)

- Male Female Unspecified

Marital Status (Check one)

- Single Married Other

SSN

Employment Status (Check one)

- Employed FT Student PT Student Other Retired Self Employed

Race (Check one)

- White Black/African American Hispanic American Indian/Alaskan Native
Asian Asian Indian Chinese Filipino
Japanese Korean Vietnamese Native Hawaiian or other Pacific Island
Samoan Guamanian or Chamorro Other I choose not to specify

Multi-Racial (Check one)

- Yes No Unknown

Ethnicity (Check one)

- Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (Check one)

- English Spanish American Sign Language Chinese French German
Tagalog Vietnamese Italian Korean Russian Polish
Arabic Portuguese Japanese French Creole Greek Hindi
Persian Urdu Gujarati Armenian I choose not to specify

Verification Question (Choose only one question by checking the question, then give the answer to that question)

- What is the name of your favorite pet?
- In what city were you born?
- What high school did you attend?
- What is your favorite movie?
- What is your mother's maiden name?
- On what street did you grow up?
- What was the make of your first car?
- When is your anniversary?
- What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking? Date began smoking, even if former smoker?

- 0 1 2 3 4 5 6 7 8 9 10
- No interest Very Interested

Current medications, including dosage if known.

If there are no current medications, check here:

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
- 2) _____ 4) _____

Occupation _____ Employer _____

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

What is your major complaint? _____

How long have you had this condition? _____

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

Do any positions make it feel worse? _____

Do any positions 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 _____

What do you think caused this condition? _____

List surgical operations and years: _____

Do you have a family physician? Name : _____

Briefly list your main health problems: _____

Has any doctor diagnosed you with Hypertension presently? Yes No If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II
If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure
If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back _____ spine in the past 28 days? Yes No
Have you had any X-rays, MRI's or CT Scans done in the past? YES NO
If yes, what was performed and at what facility? _____

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____ / _____

Your Insurance Information

Medical Insurance: _____ ID#: _____
Group #: _____ Policy Holder Name: _____
Relationship: _____ Policy Holder Date of birth: _____
Policy Holder's Employer: _____

REVIEW OF SYSTEMS

Check only the ones you now have or have had in the past.

GENERAL

NOW PAST

- Weakness
- Fatigue
- Fever
- Chills
- Night Sweats
- Fainting

SKIN

- Color Changes
- Nail Changes
- Hair Changes
- Moles
- Rashes
- Sores
- Weakness

HEAD

- Headaches
- Injuries
- Bumps
- Last Eye Exam
- Glasses
- Contacts
- Cataracts

EARS

- Hard of Hearing
- Deafness
- Ringing
- Discharge
- Earache
- Itching
- Dizziness
- Room Spins

NOSE

- Decreased Smell
- Bleeding
- Pain
- Discharge
- Obstruction
- Post Nasal Drip
- Deviated Septum
- Runny Nose
- Sinus Congestion

MOUTH

- Bleeding Gums
- Sores
- Dental Problems
- Bad Breath
- Loss of Taste
- Dry Mouth
- Ulcers
- Blisters

THROAT

NOW PAST

- Soreness
- Bad Tonsils
- Hoarseness
- Pain
- Trouble Swallowing
- Recurrent Infections

NECK

- Neck Enlargement
- Stiff Neck
- Soreness
- Lumps
- Masses

BREASTS

- Discharge
- Lumps
- Pain
- Bleeding
- Nipple Changes

Skin Changes

- Bloated

LUNGS

- Cough
- Phlegm
- Blood
- Short of Breath
- Wheezing
- Pain
- Congestion
- Inhalant Exposure

HEART

- Murmur
- Palpitations
- Rapid Heartbeat
- Swollen Extremities
- Cold Extremities
- Chest Pain/Pressure
- Varicose Veins
- Blood Clots
- Blue Extremities

BLOOD

- Anemia
- Low Blood Iron
- Easy Bruising
- Easy Bleeding
- Swollen Nodes
- Painful Nodes
- Sugar in Blood
- Red Spots

GASTROINTESTINAL

NOW PAST

- Abdominal Pain
- Nausea
- Bloated
- Belching
- Heartburn
- Indigestion
- Irregular Bowel Habits

- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Poor Appetite
- Food Intolerance
- Bloody Stools
- Black Stools

GENITOURINARY

- Urgency
- Incontinence
- Straining
- Back Pain
- Frequent Voiding
- Stones
- Burning
- Bed Wetting
- Small Stream
- Discharge
- Impotence
- Dribbling
- Cloudy Urine
- Urine Color

- Spotting Between Periods
- Menstrual Cramps
- Discharge
- Itching
- Painful Intercourse
- Irregular Periods
- Hot Flashes

- Contraception Type _____
- Age at First Period _____
- Duration of Cycle _____
- Duration of Flow _____
- No. of Pregnancies _____
- No. of Births _____
- No. of Miscarriages _____
- No. of Abortions _____
- Menstrual Flow Heavy Mod Light
- Last Period _____
- Last Pap Smear _____
- Last Vaginal Exam _____
- Last Mammogram _____
- Last Prostate Exam _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work Heavy Moderate Light Hours per day _____

Physical Work Heavy Moderate Light Hours per day _____

Exercise Heavy Moderate Light Hours per week _____ Type _____

Alcohol Beer/Week _____ Liquor/Week _____ Wine/Week _____ No. of Years _____

Caffeine Cups/Day _____ No. of Years _____
(Coffee, Tea, Cola)

Aspirin No./Day _____ No. of Years _____ Others _____

SYMPTOMS Mark the areas of your symptoms on the figure to the right.

Use the following symbols: Indicate where you have pain or other symptoms

Aches Numbness oooo Pins/Needles Stabbing ////
 Burning ^^^^^^ Tingling #####

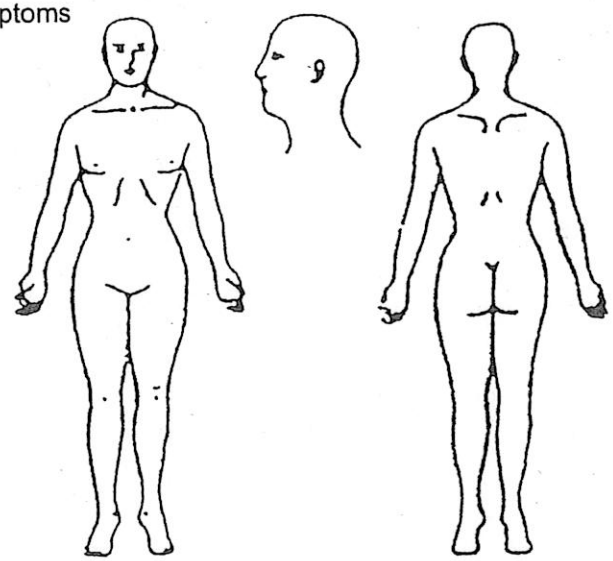
How often do you experience your symptoms? Circle One
 How bad are your symptoms now?

Constantly (76-100%) Frequently (51-75%) _____
 Occasionally (26-50%) Intermittently (0-25%) _____

How bad have they been in the past? (Past 4 weeks) Circle One

0 1 2 3 4 5 6 7 8 9 10
 None Most Severe

How are your symptoms changing? Circle One
 Getting Better Not Changing Getting Worse



NEUROLOGIC NOW PAST

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

ENDOCRINE

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

IMMUNIZATION/VACCINATION

- DPT
- Mumps
- Smallpox
- Typhoid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

BLOOD TYPE

- A + A -
- B + B -
- AB + AB -
- O + O -
- Other _____

BLOOD TRANSFUSIONS

- Date _____
- Date _____
- Date _____
- Date _____

PSYCHIATRIC NOW PAST

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

PAST MEDICAL HISTORY. Check only the ones you have had in the past.

- | | |
|--|--|
| Hay Fever <input type="checkbox"/> | Parasites <input type="checkbox"/> |
| Mumps <input type="checkbox"/> | Epilepsy <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Paralysis <input type="checkbox"/> |
| Allergies <input type="checkbox"/> | Polio <input type="checkbox"/> |
| Angina <input type="checkbox"/> | Mental Illness <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Alcoholism <input type="checkbox"/> |
| Tumor <input type="checkbox"/> | Depression <input type="checkbox"/> |
| Blood Disease <input type="checkbox"/> | Nervous Breakdown <input type="checkbox"/> |
| Leukemia <input type="checkbox"/> | Migraine <input type="checkbox"/> |
| Heart Trouble <input type="checkbox"/> | Gout <input type="checkbox"/> |
| Varicose Veins <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> |
| Phlebitis <input type="checkbox"/> | Prostate Problems <input type="checkbox"/> |
| Hypertension <input type="checkbox"/> | Sexual Problems <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | Gonorrhea <input type="checkbox"/> |
| Ulcers <input type="checkbox"/> | Syphilis <input type="checkbox"/> |
| Jaundice <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Skin Trouble <input type="checkbox"/> | Bladder Trouble <input type="checkbox"/> |
| Gallstones <input type="checkbox"/> | Kidney Stones <input type="checkbox"/> |
| Liver Trouble <input type="checkbox"/> | Kidney Infections <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/> | Dysentery <input type="checkbox"/> |

MUSCULOSKELETAL NOW PAST

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain

Date of Last Chest X-Ray _____ Normal Abnormal

Last TB Skin Test _____ Normal Abnormal

Allergies: _____

**Lancaster Depew Chiropractic
345 Dick Road
Depew, NY 14043**

Jason D. Cichocki, D.C.

Peter J. Guzinski, D.C.

Sarah L. Soper, D.C.

By Signing Below:

I authorize the office of Lancaster Depew Chiropractic and all of the doctors of Lancaster Depew Chiropractic to contact all phone numbers, including text messages and email addresses listed in my file.

In addition, I am requesting appointment reminder calls or other non-personal office matters to be sent via text or email to the following:

Printed Patient Name: _____

I choose not to be contacted by text and email

I choose to be contacted by: Text Email

Cell phone #: (_____) _____ - _____

Cell Phone Carrier: _____

Email Address: _____

I may withdrawal authorization at anytime by submitting my request in writing to the office address listed above.

Patient/Parent/Guardian Signature

Date

Activities of Daily Living

Name: _____

Date: _____

Please use the following scale to most accurately describe your current degree of pain and/or difficulty when performing the following activities.

0-No pain 1-Mild pain 2-Moderate pain 3-Severe pain NP-Not performed

1. Bathing/showering	0	1	2	3	NP
2. Bending forward/backward	0	1	2	3	NP
3. Brushing teeth	0	1	2	3	NP
4. Buttoning shirt	0	1	2	3	NP
5. Driving	0	1	2	3	NP
6. Drying hair	0	1	2	3	NP
7. Household chores	0	1	2	3	NP
8. Laundry	0	1	2	3	NP
9. Lifting less than 10 lbs	0	1	2	3	NP
10. Lifting more than 10 lbs	0	1	2	3	NP
11. Kneeling	0	1	2	3	NP
12. Making meals	0	1	2	3	NP
13. Prolonged sitting (> 30 min.)	0	1	2	3	NP
14. Putting pants on	0	1	2	3	NP
15. Putting shoes/socks on	0	1	2	3	NP
16. Reaching above the shoulder	0	1	2	3	NP
17. Restful night's sleep	0	1	2	3	NP
18. Seated to standing position	0	1	2	3	NP
19. Sexual activity	0	1	2	3	NP
20. Standing	0	1	2	3	NP
21. Squatting	0	1	2	3	NP
22. Taking out the trash	0	1	2	3	NP
23. Tying shoes	0	1	2	3	NP
24. Using lavatory	0	1	2	3	NP
25. Walking	0	1	2	3	NP

Patient Signature: _____ Date: _____

Lancaster Depew Chiropractic
345 Dick Road
Depew NY 14043
Phone: 716-681-3333
Fax: 716-681-3037

Jason D. Cichocki, D.C.

Peter J. Guzinski, D.C.

Sarah L. Soper, D.C.

Office Policy on High Deductible Plans

Dear Patient:

"High Deductible" plans are becoming more common with insurance companies. The high deductible plans require the patient to pay for services out of pocket before the insurance plan picks up any liability. The deductible amounts can vary anywhere from hundreds to thousands of dollars. The deductible will start again each year when your plan renews.

It is our office policy to collect this deductible amount at the time of service if a deductible amount is remaining. The fees are based on the fee schedules provided by each insurance company. Once the claim has been processed, if there is a difference in the amount due you will be reimbursed or a bill will be sent to you for the additional amount owed.

It is ultimately the patient's responsibility to know if their plan has a high deductible and if it has been met for the year. If you have any questions about this please contact your insurance carrier and they can provide you with this vital information.

If you have any questions or concerns regarding this please do not hesitate to ask our staff members.

I HAVE READ THIS EXPLAINATON AND ACCEPT FINANCIAL RESPONSIBILTY FOR ANY CHARGES NOT COVERED BY MY INSURANCE.

Date

Print Name

Patient's Signature

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PATIENT NOTIFICATION OF FINANCIAL RESPONSIBILITY

I understand that I may be financially responsible for any charges incurred at this office, including co-payments, deductibles and charges denied or not covered by my insurance company.

All copay's, deductibles, co-insurance, etc are required to be paid at the time of service. If a claim comes back with a balance that is still due the balance must be paid in full upon receipt of the bill or at the next visit, whichever comes first.

My signature below verifies my acknowledgement of the above policy. If I am unable to make payment in full I must make pre-arrangements with the billing department. The billing department reserves the right to make any exceptions to this policy on an individual basis.

Print Patient Name

Signature of Patient or Parent/Guardian

Date

Acknowledgement of understanding of notice of Privacy Practices for protected health information

I acknowledge that I understand Lancaster Depew Chiropractic's notice of Privacy Practices for protected health information. The original HIPPA form can be reviewed at the front receptionist desk.

Print Patient Name

Signature of Patient or Parent/Guardian

Date

I authorize the following individual(s) listed below to discuss my health information with Lancaster Depew Chiropractic.

1. Name: _____ Relationship: _____ Phone #: _____

2. Name: _____ Relationship: _____ Phone #: _____

3. Name: _____ Relationship: _____ Phone #: _____



Lancaster Depew Chiropractic
345 Dick Road
Depew, NY 14043
Phone 716-681-3333
Fax 716-681-3037

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events



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of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I approve and direct Dr. _____, other doctors or others judged by him or her (including interns, assistants, and/ or preceptors) to perform the appropriate care and treatment not limited to adjustment. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive interaction or treatment as is deemed appropriate for my circumstance.

Patient Name	Signature	Date
Parent or Guardian	Signature	Date
Witness Name	Signature	Date

Doctors Checklist

- Benefits/ risks/ alternatives were discussed with patient and patient agreed to begin care.
- We discussed the possible side effects of the treatment performed in this office, that post treatment soreness is to be expected.
- The importance of performing all prescribed home care was discussed.
- The patient was made aware of the possibility of symptoms worsening improving.
- Diagnoses were shared with patient and the patient verbalized an understanding.
- Alternative treatment options for this condition were discussed with this patient.

Doctor's Initial _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____

Fax #: _____

I, _____ request the following information:
(Patient's name)

records reports doctors notes billing information

Concerning my: Auto Accident Work Accident Other

To be released to: **Lancaster Depew Chiropractic**
345 Dick Road
Depew, NY 14043
Fax #: (716) 681-3037

For the purpose of: Treatment – this will allow the doctor to be well informed of my care outside of this office.

According to Section 25252 of the Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

Signed: _____

Date: _____

Relationship to patient: _____

DOB: _____

LANCASTER DEPEW CHIROPRACTIC
345 DICK ROAD
DEPEW, NY 14043
(716) 681-3333 (phone)
(716) 681-3037 (fax)