

St. Henry Chiropractic, LLC Case History

Name _____ Sex M F Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

H. Phone _____ Cell Phone _____

E-mail _____ @ _____ May we contact you by e-mail? Yes No

Marital Status: S M W D Spouse's Name: _____

In Case of Emergency, Contact: _____ Phone _____

Referred by _____

Occupation _____ Employer _____ W.Phone _____

Have you ever received Chiropractic Care? Yes No If yes, who? Dr. _____ when? _____

Who is your medical doctor? _____ last seen when? _____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Due to: Injury work injury auto accident gradual onset other _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? No Yes Where? _____

Do you have any numbness or tingling in your body? No Yes Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, and how long does it last? _____

Does anything make the complaint worse? _____

Does anything make the complaint better? _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for this complaint: _____

3. Past Health History:

A. Previous illnesses you've had in your life: _____

B. Previous injury or trauma: _____

C. Allergies _____

D. Medications & Supplements:

E. Surgeries:

Date or Year	Type of Surgery
_____	_____
_____	_____
_____	_____

Any chance you could be pregnant now? No Yes

What was the date of the beginning of your last menstrual period? _____

3. Social and Occupational History:

A. Job description: _____

B. Hours of sleep: _____

C. Alcohol Consumption: _____ **Tobacco (packs per day):** _____

D. Coffee/Tea/Soft Drinks (cups per day): _____

E. Exercise (describe): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. I hereby accept full responsibility for payment of services rendered me, and for charges not covered by insurance.

Patient or Guardian Signature _____ Date _____

St. Henry Chiropractic, LLC
570 E. Kremer Hoying Rd. Suite H St. Henry, OH 45883 (419) 678-4873

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient at **St. Henry Chiropractic, LLC**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Authorization for Release of Records:

I hereby request the release of any and all records, including x-rays, MRIs, and CTs.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,
ie. home answering machines or voicemails? Yes [] No []

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

EHR Certification – Patient Information 2

Dear Patient: The US government is now requiring that we supply them with the following information:

PATIENT DEMOGRAPHICS:

Staff: (To be entered in EZnotes through "Edit Patient Info")

Name: (Print clearly) _____ Today's Date: _____

Date of Birth: _____

Ethnicity: (Please circle)

Race: (Please circle all that apply)

Hispanic or Latino	Not Hispanic or Latino
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White	American Indian/ Alaskan Native	Asian
Black/African American	Native Hawaiian/ Pacific Islander	

Preferred Language: (Please circle)

English	Spanish	French	German	Italian
Mandarin	Cantonese	Tagalog	Japanese	Other _____

If there is an emergency, in which language would you like to receive the message?

What is your preferred method of contact?

Phone Number: _____

Home	Work	Cell
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Phone Call: ☐ Text: ☐ E-Mail: ☐

If email was not your preferred method, please give your email address here:

Mailing Address: _____

For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name?

Secret Question: _____

Secret Answer: _____

OFFICE USE ONLY

Vitals: In EZnotes, complete by 1) Going to "Exam" screen
2) "Select by region"
3) Then select "Vitals"

Blood Pressure: ____ / ____ Height: ____ Weight: ____

Smoking Status:

Smokes every day

Smokes some days

Former Smoker

Never Smoked

If you smoke, how many cigarettes do you smoke per day? ____

PRESCRIBED MEDICINES

Check here if not taking any medications: ☐

Medication: i.e. Lipitor	# of MD refills issued:	Quantity of Pills:	Strength: i.e. 10 mg	MD's instruction: i.e. 1 per day

Are you allergic to any medicines? Please list each drug on a new line: Check

here if you do not have any medical allergies: ☐

Name of Drug: i.e. penicillin	Symptom: i.e. headache	Severity: i.e. Mild, Moderate, Severe, Fatal

Have you been diagnosed with either of the following: (Please circle:)

Asthma?	Diabetes?	Hypertension (high blood pressure)?
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I would like to electronically have access to my health information: (Please initial box)

☐**OFFICE USE ONLY**

Timely access: In EZnotes, complete by 1) Going to "Edit Patient" section for this patient
3) Select "Asked *Timely Access*"

☐

Completed?

Medications In EZnotes, complete by

1) Going to "Edit Patient"
2) "Edit /View Patient's Data"
3) "Prescriptions/Allergies"

Entered into EZnotes by (name): _____ Date & Time: _____

☐

Completed?