CASEY CHIROPRACTIC

DONALD R. CASEY, D.C.

2865 RING RD, STE 110 ELIZABETHTOWN, KY 42701 (270) 769-5400

Patient Name: _____ Preferred Name: _____ Date: _____

Address_____ City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Reminder method: Text_____ Call_____ Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Occupation _____

Employer _____

Emergency Contact and Phone Number: _____

Referred by: _____

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

Name of most recent Chiropractor: _____

1. **Past Health History:**
   - **A. Surgeries:**

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

   - **B. Previous Injury or Trauma:** _____

     Have you ever broken any bones? Which? _____

   - **C. Allergies:** _____

2. **Family Health History:**

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease
□ Diabetes □ Other _____ □ None of the above

Deaths in immediate family:

Cause of parents' or siblings' death Age at death

_____

_____

_____

_____

3. **Social and Occupational History:**

   A. **Job description:** _____

   B. **Work schedule:** _____

   C. **Recreational activities:** _____

   D. **Lifestyle:**

      Level of Exercise: _____

      Alcohol Use: _____

      Tobacco Use: _____

      Drug Use: _____

      Diet: ____Poor _____Fair _____Good _____Excellent

4. **Medications:**

   Medication Reason for taking

   _____

   _____

   _____

   _____

   _____

5. **If female, are you possibly pregnant?** Yes___ No___

6. Primary Symptom _____

- On a scale from 0-10, with 10 being the worst possible pain, please circle the number that best describes the symptom most of the time:

  No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

- Did the symptom begin suddenly or gradually? (circle one)

- On what date did the symptom begin? _____

- What caused the symptom to begin? _____
  _____

- What makes the symptom worse? (please describe): _____
  _____

- What makes the symptom better? (circle all that apply):
  nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, over the counter medication, other (please describe):
  _____

- Describe the quality of the symptom (circle all that apply): Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff

- Does the symptom radiate to another part of your body (circle one): yes no
  If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
  No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic
  - Other _____

Do you have any of the following?

Constitutional
__Unexplained Weight Loss
__Fatigue or weakness
__Fever

Eyes
__Glaucoma
__Cataracts
__Double Vision

Ears, Nose, Throat
__Difficulty Hearing
__Buzzing or Ringing in Ears
__Dizziness
__Loss of Smell
__Sinus Trouble
__Difficulty Swallowing
__Loss of Taste

Skin
__Rashes
__Hives
__Itching

Allergic/Immunologic
__Hives/Hay Fever

Respiratory
__Cold/Flu/Cough
__Coughing Blood
__Wheezing

Gastrointestinal
__Nausea/Vomiting
__Constipation
__Diarrhea
__Digestive Problems

Genitourinary
__Blood in Urine
__Bladder Leakage
__Burning/Frequent Urination

Musculoskeletal
__Spinal Pain
__Joint Swelling
__Joint Stiffness

Cardiovascular
__Chest Pain
__Shortness of Breath
__Racing Heartbeat
__Fainting Spells

Neurological
__Headaches
__Memory Loss
__Tremors
__Numbness
__Loss of Strength
__Seizures

Mental Status
__Anxiety/Depression
__Mood Swings
__Difficulty Sleeping
__Stress

Endocrine
__Loss of Hair
__Heat/Cold Intolerance
__Diabetes
__Excessive Sweating
__Change in Appetite

Hematologic/Lymphatic
__Ease of Bruising
__Gums Bruise Easily
__Enlarged Glands

Have you had any of the following symptoms in the last 30 days?
__Pain worse at night __Constant pain unrelated to motion__Unexplained weight loss
__Loss of bowel or bladder control__Bacterial infection__Surgery__Fever or chills

***NOTICE TO PATIENTS:** Full payment is due at the end of each visit for services rendered. I give permission to the clinic to perform necessary tests and treatments.

AGREEMENT FOR PATIENTS WITH INSURANCE: I will pay all co-payments or unmet deductible balances at the time of services, and I authorize direct payment from my insurance company to this office. I understand that I am personally responsible for any remaining balance this office does not collect from insurance proceeds. I authorize the release of any information pertinent to my case to the insurance company.

Signature: _____ Date: _____

Casey Chiropractic
Acknowledgement of Receipt of Notice

PATIENT ACKNOWLEDGEMENT
By signing below, I acknowledge receipt of access to this clinic's Notice of Privacy Practices with an effective date of September 1, 2013. This notice is located on the clinic's website (elizabethtownchiropractic.net) and in the clinic.

Patient Name (print) _____

Patient Signature _____

Date _____

If signed by someone other than the patient, please indicate relationship:
❒ parent or guardian of minor patient
❒ guardian or conservator of an incompetent patient
❒ beneficiary or personal representative of deceased patient
❒ other (specify)

Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to understand our financial policy.

Most health and accident insurance companies cover chiropractic care. Keep in mind that your insurance policy is a contract between you and your insurance company.

If you have insurance, we will call your insurance company to determine your coverage for chiropractic care. However, information provided by phone (or written in an insurance policy book) does not guarantee the payment of benefits. Insurance companies cannot establish whether benefits will be paid until an actual claim is submitted. We cannot take responsibility for knowing which services your insurance company will or will not cover. Not all insurance plans cover all services.

Ultimately, you are the party responsible for payment for all health care services we provide to you at our clinic. As a courtesy to you, we will gladly submit to your insurance company invoices for services we provide to you.

We have made in-network arrangements with some insurance companies. For patients who have policies with these companies, we will bill the insurance company and collect the required co-payment or unmet deductible balance at the time of your visit.

If you are insured by a company with which we do not have a prior arrangement, we will submit the claim for you. However, payment for your care is due at the time of services.

PAYMENT RESPONSIBILITY

I will pay all co-payments or unmet deductible balances at the time of services.

I understand that I am personally responsible for any remaining balance this clinic does not collect from my insurance company. In the event my insurance company does not compensate your clinic within thirty (30) days after billing, I will pay the remaining balance.

I have read and understand this financial policy and agree to be bound by its terms.

_____ _____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of patient