Leitner Chiropractic

CONFIDENTIAL CASE HISTORY

Name _____Age _____Date _____

Address _____City _____State____Zip_____

Phone (Home)_____Email_____

Phone (cell)_____ Phone (work)_____ Date of Birth _____

Gender: M /F Height_____Weight_____ Children _____

Occupation _____Employer _____

Insurance Company_____Insured's Name _____

Insured's Date of Birth _____ Insured's ID. # or S.S. # _____

Dependent? ❑ Primary insurance holder name and ID #_____

Present condition due to an injury? ❑ Yes ❑ No ❑ On the Job ❑ Auto Accident ❑ Other _____

Has the accident been reported? ❑ Yes ❑ No ❑ To Employer ❑ Auto Carrier ❑ Other _____

Referred by_____ Emergency contact: _____

HEALTH REPORT:

Reason for seeking care:_____

List any other doctors seen for this: _____

List any diagnosis and treatment received: _____

X-Ray, CT Scan or MRI results:_____

Have you had similar complaints or injuries before? ❑ Yes ❑ No If yes, explain:

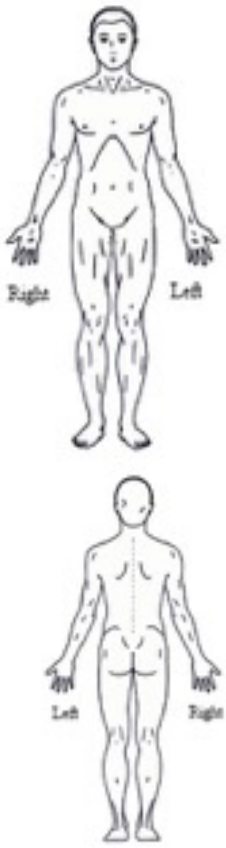
_____

Have you received chiropractic treatment previously? ❑ Yes ❑ No If yes, for what condition:

_____

Have you been treated for any health condition by a physician in the last year? ❑ Yes ❑ No

If yes, explain: _____



On the diagram, please mark your area(s) of pain:

Are you in pain ❑ Yes ? ❑ No ? If yes, indicate where on the drawing. Or, please explain below:

_____

Rate your pain at its worst in the last week 0 1 2 3 4 5 6 7 8 9 10

Rate your current pain right now 0 1 2 3 4 5 6 7 8 9 10

When did you first notice this (days/weeks/months/years)?

_____

Was there a specific cause?

_____

Are your symptoms **always present**? **Episodic**? **Specific** to a motion or position? Is it **tight**? **Painful**? **Sharp**? **Sometimes sharp**? **Dull**? **Aching**? **Sore**? Please explain:

_____

What activities (lying down, pills, heat, etc.) reduce/relieve your symptoms?

_____ _____ _____

Which activities (sitting, standing, desk work) aggravate your symptoms?

_____ _____ _____

Is this condition worse during certain times of the day Y ❑ ? N ❑ ?

Is this condition interfering with Work? ❑? Sleep? ❑? Other?_____

Is this condition progressively getting Worse? ❑? Better? ❑? Staying the Same ❑ ?

Have these symptoms occurred before? Yes ❑? No ❑?

If yes, when? _____ _____ _____

What, if any, health care specialists have you seen for these symptoms?

_____

What, if any, medications have you taken for these symptoms?

_____

Are you currently taking medication for other issues? Yes ❑? No ❑?

If yes, list medications and the reasons you are taking them:

_____

_____

Do you take Vitamins/Supplements? Y ❑? N ❑? If yes, type and how often:

_____

List the approximate dates of any surgery:

_____

Family History: Health conditions, age of death and cause of death.

Father: _____

Mother: _____

Brother/s & Sister/s: _____

Do you smoke? Y ❑? N ❑?

Alcohol? Y ❑? N ❑? Daily ❑? Weekly ❑? Social Occasions ❑?

Caffeinated drinks per day_____

Mark each item below with a **C** (Current) or **P** (Past) for each sign or symptom you have or previously had:

GENERAL SYMPTOMS

Convulsions C ❑ P ❑
Dizziness C ❑ P ❑
Fainting C ❑ P ❑
Headache C ❑ P ❑
Nervousness C ❑ P ❑
Numbness C ❑ P ❑

MUSCLES & JOINTS

Low Back Problems C ❑ P ❑
Pain between Shoulders C ❑ P ❑
Neck Problems C ❑ P ❑
Arm Problems C ❑ P ❑
Leg Problems C ❑ P ❑
Swollen Joints C ❑ P ❑
Painful Joints C ❑ P ❑
Stiff Joints C ❑ P ❑
Sore Muscles C ❑ P ❑
Weak Muscles C ❑ P ❑
Walking Problems C ❑ P ❑
Sprains/Strains C ❑ P ❑
Broken Bones C ❑ P ❑

CARDIO-VASCULAR

High Blood Pressure C ❑ P ❑
Heart Attack C ❑ P ❑
Pain over Heart C ❑ P ❑
Poor Circulation C ❑ P ❑
Heart Trouble C ❑ P ❑
Rapid Heart C ❑ P ❑

Slow Heart C ❑ P ❑
Strokes C ❑ P ❑
Swelling Ankles C ❑ P ❑
Varicose Veins C ❑ P ❑

EAR/NOSE/THROAT

Earache C ❑ P ❑
Ear Noises C ❑ P ❑
Enlarged Thyroid C ❑ P ❑
Frequent Colds C ❑ P ❑
Hay Fever C ❑ P ❑
Nasal Blockage C ❑ P ❑
Nose Bleeds C ❑ P ❑
Pain Behind Eyes C ❑ P ❑
Poor Vision C ❑ P ❑
Sinusitis C ❑ P ❑
Sore Throats C ❑ P ❑
Tonsillitis C ❑ P ❑

GASTRO-INTESTINAL

Belching/Gas C ❑ P ❑
Colon Problems C ❑ P ❑
Constipation C ❑ P ❑
Diarrhea C ❑ P ❑
Excessive Hunger C ❑ P ❑
Excessive Thirst C ❑ P ❑
Gall Bladder Trouble C ❑ P ❑
Hemorrhoids C ❑ P ❑
Liver/Gallbladder C ❑ P ❑
Nausea C ❑ P ❑
Abdominal Pain C ❑ P ❑
Ulcer C ❑ P ❑
Poor Appetite C ❑ P ❑
Poor Digestion C ❑ P ❑
Vomiting C ❑ P ❑
Vomiting Blood C ❑ P ❑
Black Stool C ❑ P ❑
Bloody Stool C ❑ P ❑
Weight Loss/Gain C ❑ P ❑

RESPIRATORY

Asthma C ❑ P ❑
Chronic Cough C ❑ P ❑
Difficulty Breathing C ❑ P ❑
Spitting Blood C ❑ P ❑
Spitting Phlegm C ❑ P ❑

GENITO-URINARY

Blood in Urine C ❑ P ❑
Frequent Urination C ❑ P ❑
Kidney Infection C ❑ P ❑
Painful Urination C ❑ P ❑
Prostate Problems C ❑ P ❑
Loss of Bladder Control C ❑ P ❑

SKIN OR ALLERGIES

Boils C ❑ P ❑
Bruising Easily C ❑ P ❑
Dryness C ❑ P ❑
Eczema/Rash/Dermatitis C ❑ P ❑
Hives C ❑ P ❑
Itching C ❑ P ❑
Sensitive Skin C ❑ P ❑
Allergy C ❑ P ❑

FOR WOMEN ONLY

Birth Control **C** ❑ P ❑
Hormone Replacement **C** ❑ P ❑

Cramps/Backaches **C** ❑ P ❑
Excessive Flow **C** ❑ P ❑
Hot Flashes **C** ❑ P ❑
Irregular Cycle **C** ❑ P ❑
Miscarriage **C** ❑ P ❑
Painful Periods **C** ❑ P ❑
Vaginal Discharge **C** ❑ P ❑
Breast Pain **C** ❑ P ❑
Pregnant at this Time? Y ❑ N ❑

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health, personal information or insurance. I consent to examination and treatment for my present condition and for any future conditions for which I seek treatment from Dr. Leitner or Dr. Taylor.

Patient Signature_____Date_____

Billing and Cancellation Policies

Charges are assessed on an itemized basis for each service provided, and it is understood that the patient assumes financial responsibility for the full amount. Patients with chiropractic health insurance benefits assume financial responsibility for any portion not covered by their carrier. **Payment is required at the time of the office visit.**

A $35 charge will be applied if an appointment is missed/cancelled/rescheduled with 24 hours of the original appointment.

I have checked my health care benefits and know my chiropractic coverage. If not, I acknowledge that I may be charged the full cost of my treatment.

Patient Signature_____Date_____

Thank you for taking the time to read this. If you have any questions or concerns, please do not hesitate to ask.

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his hands or a mechanical device in order to mobilize your joints. You may feel a "click" or "pop" such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, including a variety of soft tissue massage or joint mobilization techniques, may also be used.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications, while rare, could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare"—about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated to be one in four million (1:4,000,000) to one in twenty-five million (1:25,000,000). As a comparison, the risk of an exercise stress test performed during a physical examination on the general population is approximately one in ten thousand (1:10,000). The probability of adverse reaction due to ancillary procedures is also considered "rare."

Other treatment options which could be considered may include the following:

• *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

• *Medical care,* typically anti-inflammatory drugs, muscle relaxers , and analgesics. Risks of these drugs may include a multitude of undesirable side effects and patient dependence.

• *Surgery* may include the risk of adverse reaction to anesthesia, as well as an extended convalescent period.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____ _____ _____

Printed Name **Signature** **Date**