CONFIDENTIAL CASE HISTORY FILE

Cook Chiropractic
2045 Scott Blvd phone 254.778.6100
Temple, TX 76504-6979 fax 254.778.6120

Date: _____

Full Legal Name: _____ **Name you prefer:** _____

Address: _____ **City/State/Zip** _____

Phone: (home) (____) _____ **(work)** (____) _____ **Soc Sec#** ____ - ____ - ____

Birth date: ____/____/____ **Age:** _____ **Sex:** _____ **Marital Status:** S M W D Sep

Spouse's Name: _____ **# Children** _____ **Years of Education** _____

Emergency Contact: _____ **Phone:** (____) _____

Your Employer: _____ **Phone:** (____) _____

Employer's Address: _____ **City/State/Zip** _____

Job title: _____ **Supervisor Name:** _____

e-mail address: _____ **Referred by:** _____

MEDICAL HISTORY *(please be complete)*

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accident injuries (include dates): _____

List any on the job injuries (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.):

_____

List all current over-the-counter and prescription medications used (include reason used):

_____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.)

_____

Have you been under a physician's care in the past year? ☐ **no** ☐ **yes (reason)** _____

When was your last physical examination? _____ **Dr:** _____

Have you ever been under chiropractic care? ☐ **no** ☐ **yes (describe)** _____

If female, is there a possibility that you are pregnant? ☐ **no** ☐ **yes**

Do you smoke/use tobacco? ☐ **no** ☐ **yes** **Exercise habits?** ☐ **never** ☐ **occasional** ☐ **frequent**

Check any of the following symptoms you have noticed: (▢ = Previously, ☐ = Now)

▢ ☐ Headaches	▢ ☐ Low back pain	▢ ☐ Sensitive to light or sound
▢ ☐ Dizziness or light-headed	▢ ☐ Leg/foot numbness/tingling	▢ ☐ Visual or hearing disturbance
▢ ☐ Jaw pain, clicking, or locking	▢ ☐ Leg/foot fatigue/weakness	▢ ☐ Memory loss/problems
▢ ☐ Pain or difficulty swallowing	▢ ☐ Leg pain with walking	▢ ☐ Irritability or depression
▢ ☐ Neck pain or stiffness	▢ ☐ Abdominal pain	▢ ☐ Fatigue or loss of energy
▢ ☐ Shoulder pain	▢ ☐ Nausea or vomiting	▢ ☐ Fainting or convulsions
▢ ☐ Mid back pain	▢ ☐ Diarrhea or constipation	▢ ☐ Trouble with balance or coordination
▢ ☐ Chest pain or cough	▢ ☐ Blood in urine or stool	▢ ☐ Sleep disturbances/problems
▢ ☐ Pain/trouble breathing	▢ ☐ Difficulty or pain w/ urination	▢ ☐ Rashes (face, body, limbs)
▢ ☐ Arm/hand numbness/tingling	▢ ☐ Difficulty with sexual function	▢ ☐ Joint pain or swelling
▢ ☐ Arm/hand fatigue/weakness	▢ ☐ Abnormal menstrual periods	▢ ☐ Pain with exertion (activity, climbing stairs, etc.)

HAVE YOU HAD *ANY* OF THE FOLLOWING:

NOW:

- ☐ Pain worse at night
- ☐ Constant pain
- ☐ Unexplained weight loss
- ☐ Recent bacterial infection (30 days)
- ☐ Loss of bowel or bladder control
- ☐ Urinary discharge
- ☐ Recent surgery (30 days)

EVER:

- ☐ History of cancer
- ☐ History of IV drug use
- ☐ History of blood transfusion

Information about your current condition/complaints

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What is your primary complaint/problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: ☐ **Constant** ☐ **Intermittent** **Is your condition getting worse?** _____

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____
2. _____
3. _____

Have you had: ☐ **Xray** ☐ **MRI or CAT Scan** ☐ **EMG** ☐ **Bone Scan** ☐ **Blood Work**

Who is your family medical doctor: _____

List all home remedies tried for this problem: _____

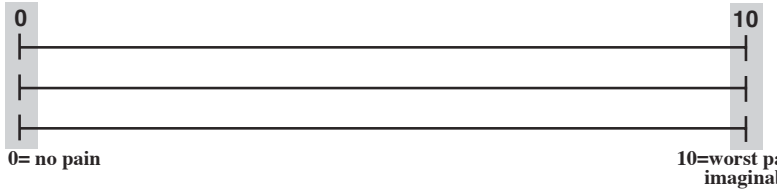
Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) **work** _____ **sleep** _____ **normal daily routine** _____

Have you had symptoms like this before? ☐ **no** ☐ **yes (describe)** _____

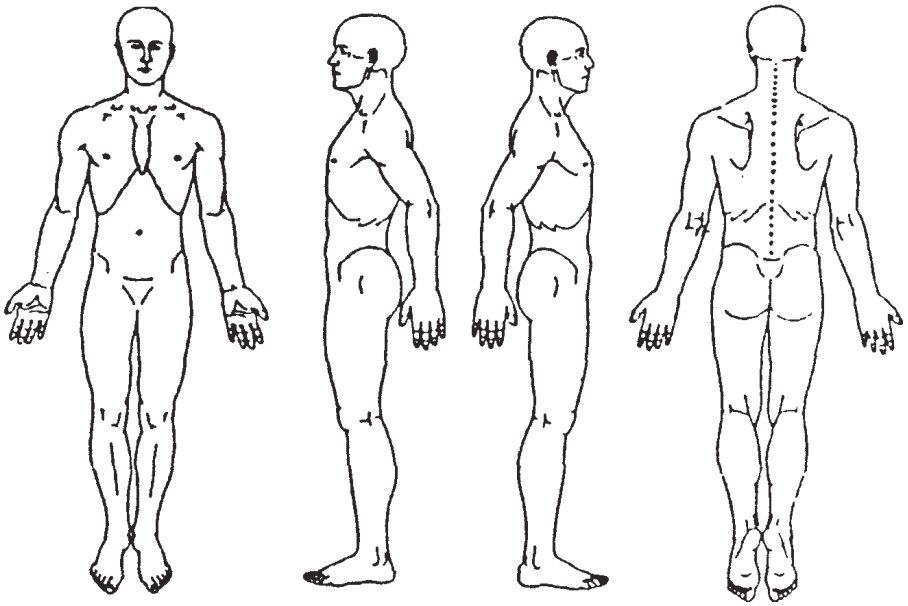
Regarding your main complaint:

How bad is your pain?
(make a slash on all 3 scales)



Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
✻ = sharp/stab
ooo = numb/tingle
⟶ = shooting
/ / / / = stiff/tight



NOTICE TO NEW PATIENTS: **Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.**

Patient Signature: _____ **Date** _____

Cook Chiropractic

2045 Scott Blvd | Temple, TX | 254.778.6100 ofc | 254.778.6120 fx
cookchiro.net | cookchiro@yahoo.com

Authorization and Assignment

In consideration of your undertaking to care for me I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to Cook Chiropractic of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such insurance company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action whether in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been directly from me. I understand that whatever amounts you do not collect from insurance companies, contractually obligated, you will refrain from attempts and efforts to collect amounts owed directly from me. I understand that whatever amounts you do not collect from insurance company's proceeds, whether it is all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in the state of Texas.
5. I further agree that this authorization and assignment is irrevocable until all monies owed are paid to Cook Chiropractic in full.

Signature:_____ Date:_____

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical modalities and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Kirk Cook, D.C. and/or other licensed doctors of chiropractic who now or in the future will treat me while employed by, working, or associated with, or serving as back-up for Kirk Cook, D.C., including those working at the clinic or office of Cook Chiropractic. I have had the opportunity to discuss with Kirk Cook, D.C. and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fracture, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, in my best interest. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present conditions(s) and for any future condition(s) for which I seek treatment.

Patient's Signature/Parent/Legal Representative:_____ Date:_____

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provisions of healthcare services, Cook Chiropractic creates and maintains health records and other information describing among other things, my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. I understand that I can ask to have a copy of the Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that the organization reserves the right to change their Notice and Practices. By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made reliance on my prior consent. This consent is given freely with the understanding that:

1. any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information, and agree any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed.

Patients Printed Name:_____ Date:_____

Patients Signature:_____ Date:_____