

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_ Work: \_\_\_\_\_  
Email: \_\_\_\_\_ Gender: M / F Marital Status: Single / Married / Other  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Student Status: Full Student / Part Student / Non-Student Employed: Y / N  
Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline Preferred Language: English / Decline / Other: \_\_\_\_\_  
Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline  
\*Referred By: (Name): \_\_\_\_\_ Family / Friend / Co-Worker / Doctor / Other Source

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_  
Relationship: Child / Parent / Spouse / Other: \_\_\_\_\_

## FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain): \_\_\_\_\_

### PRIMARY INSURANCE

Insurance Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:

Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## RESPONSIBLE PARTY

Who is responsible for payment? Self / Other - (Relationship) \_\_\_\_\_

Other than Self:

Name: (First MI Last) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

Patient No: \_\_\_\_\_

# ACCIDENT/INJURY QUESTIONNAIRE

Name: (Last, First MI) \_\_\_\_\_

Today's Date: \_\_\_\_\_



## AUTOMOBILE ACCIDENT – ADDITIONAL INFORMATION

- Was anyone else in the vehicle with you? ☐ No ☐ Yes - (Number of people) \_\_\_\_\_
- You were? ☐ Front seat – Driver / Passenger ☐ Rear Seat– Behind Driver / Middle / Behind Passenger / 2<sup>nd</sup> Row / 3<sup>rd</sup> Row
- Name of Driver, if not self: \_\_\_\_\_ Name of Driver of other vehicle: \_\_\_\_\_
- Did airbags deploy? ☐ No ☐ Yes Did Police arrive? ☐ No ☐ Yes Using Seatbelt? ☐ No ☐ Yes
- Did you strike the windshield or object in car? ☐ No ☐ Yes - (Describe) \_\_\_\_\_
- Were you knocked unconscious? ☐ No ☐ Yes (How long?) \_\_\_\_\_
- Where was your vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: \_\_\_\_\_
- Where was the other vehicle impacted? Front / Rear / Passenger Side / Driver's Side / Other: \_\_\_\_\_
- Your Auto Ins: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_ Phone #: \_\_\_\_\_
  - Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- Other's Auto Ins: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_ Phone #: \_\_\_\_\_
  - Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



## WORKER'S COMPENSATION INJURY – ADDITIONAL INFORMATION

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_



## GENERAL ACCIDENT/INJURY INFORMATION – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ AM / PM

Please describe the accident in as much detail as possible? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Before the accident/injury:

- Have you ever had any complaints in the involved area before? ☐ No ☐ Yes
  - If yes - Were they present at the time of the accident/injury? ☐ No ☐ Yes
    - If yes - Summarize these complaints prior to the accident: \_\_\_\_\_
- Were you capable of performing all of your work activities without restriction? ☐ No ☐ Yes

### At the time of the accident/injury:

- Did you feel pain immediately after the accident? ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? \_\_\_\_\_
- Were you taken anywhere after the accident? ☐ No ☐ Yes ☐ Later that day ☐ Next day ☐ When? \_\_\_\_\_
  - If yes, How? \_\_\_\_\_ Where? \_\_\_\_\_
  - If yes, Did you receive treatment? ☐ No ☐ Yes - (Describe) \_\_\_\_\_

### Since the accident/injury:

- Are your symptoms: ☐ Improving? ☐ Getting Worse? ☐ The Same?
- Are your work activities restricted as a result of this accident/injury? ☐ No ☐ Yes - (How?) \_\_\_\_\_
- Have you missed any work since this accident? ☐ No ☐ Yes - (Dates?) \_\_\_\_\_
- Have you retained an Attorney? ☐ No ☐ Yes - Name: \_\_\_\_\_ Phone: \_\_\_\_\_
  - Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient No: \_\_\_\_\_

# PATIENT CASE HISTORY

## HISTORY OF CURRENT CONDITION

**Describe Major Complaint:** \_\_\_\_\_

**Describe any Secondary Complaints:** \_\_\_\_\_

**Describe WHEN and HOW this began:** \_\_\_\_\_

**Grade Intensity/Severity of Complaint:** None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)

**Quality of the complaint/pain:** Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: \_\_\_\_\_

**How frequent is the complaint present?** Off & On / Constant

**Does this complaint radiate/shoot to any areas of your body?** No / Yes (Describe) \_\_\_\_\_

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: \_\_\_\_\_

**Does anything make the complaint better?** Ice / Heat / Rest / Movement / Stretching / OTC / Other: \_\_\_\_\_

**Does anything make the complaint worse?** Sit / Stand / Walk / Lying / Sleep / Overuse / Other: \_\_\_\_\_

**Which daily activities are being affected by this condition?** (Describe) \_\_\_\_\_

**For this CURRENT condition, have you:**

• Received any other treatment? None / DC / MD / PT / Massage / ER / Other: \_\_\_\_\_ Where? \_\_\_\_\_

• Had any diagnostic testing? X-rays / MRI / CT / Other: \_\_\_\_\_ When and Where? \_\_\_\_\_

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

## Medications and Supplements:

**Allergies to Medications:** NONE

Name	Reaction

**Current Medications & Supplements:** NONE

Name	Dosage	Frequency	Method

## Past Health History: (Please list any past...)

**Number of Falls in the last 24 months:** \_\_\_\_\_ **Injuries?** Y or N

**Surgeries:** NONE

Date	Area of the Body	Reason

**Major Injuries / Traumas / Hospitalizations:** NONE

Date	Describe

**Patient No:** \_\_\_\_\_

## Family Health History:

N/A

**List relevant major health problems of First degree relatives:**

Problem	Parent (M or F)	Sibling (B or S)	Child (S or D)

## Social and Occupational History:

**Smoking/Tobacco Use:** Every Day / Some Days / Former / Never

Habit	Type	Amount	Year Started
Smoking			
Tobacco			
Alcohol			
Caffeine			
Rec. Drugs			

**Education:** High School / College Grad. / Post Grad. / Other:

Lifestyle	Describe
Hobbies	
Recreation	
Exercise	
Diet	
Work	
Other	

**Are you currently experiencing any of these symptoms? (Check all the apply)**  
**Many of the following conditions respond to Chiropractic and Acupuncture treatment.**

**General: (constitutional)**

- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ None in this Category

**Musculoskeletal:**

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems \_\_\_\_\_
- ☐ Leg Problems \_\_\_\_\_
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones \_\_\_\_\_
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Neurological:**

- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Mind/Stress:**

- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Genitourinary:**

- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Gastrointestinal:**

- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Cardiovascular & Heart:**

- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Respiratory:**

- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Eyes and Vision:**

- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Ears, Nose and Throat:**

- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Endocrine, Hematologic, and**

**Lymphatic:**

- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Skin and Breasts:**

- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Women Only:**

**Are you pregnant?**

- ☐ Yes - Due Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- ☐ No - Last Menstrual Period  
\_\_\_\_/\_\_\_\_/\_\_\_\_

- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: \_\_\_\_\_
- ☐ None in this Category

**Pregnancies:**

Date	Outcome

Comments: \_\_\_\_\_

*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 to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.*

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Treating Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_

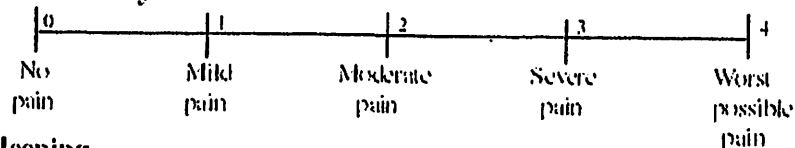
Patient No: \_\_\_\_\_

# Functional Rating Index

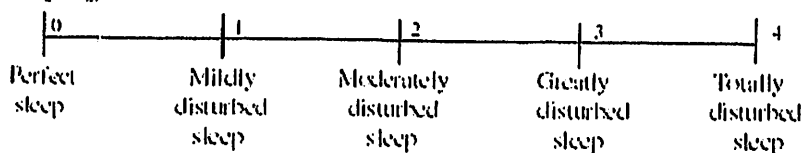
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

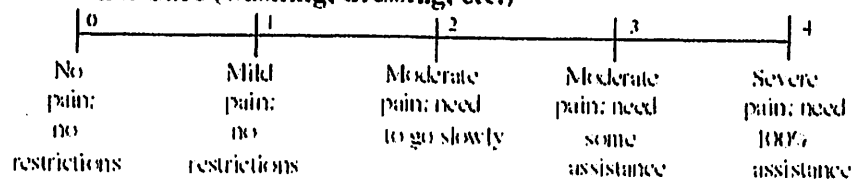
## 1. Pain Intensity



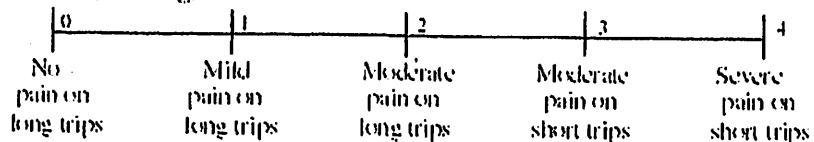
## 2. Sleeping



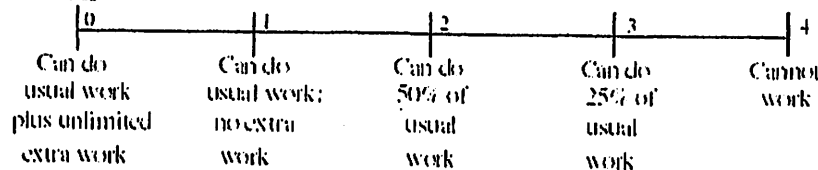
## 3. Personal Care (washing, dressing, etc.)



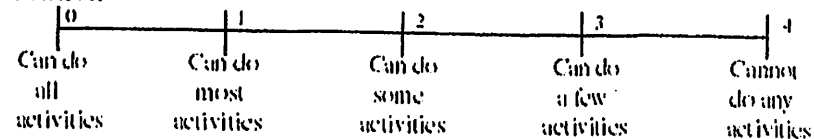
## 4. Travel (driving, etc.)



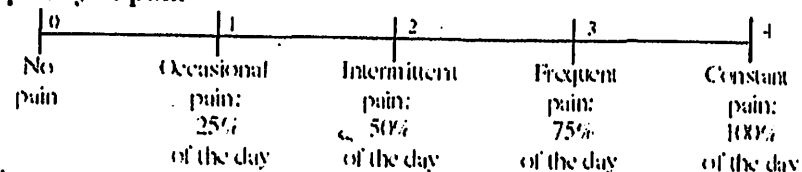
## 5. Work



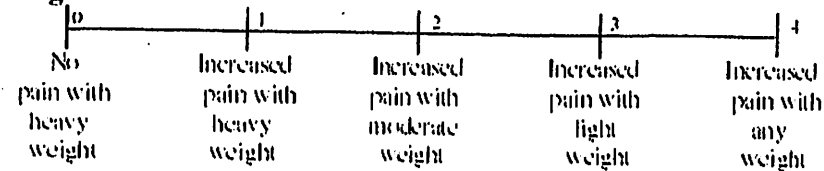
## 6. Recreation



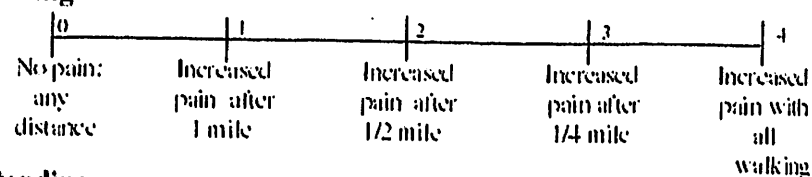
## 7. Frequency of pain



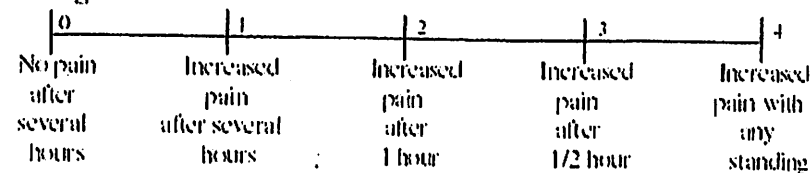
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_

PRINTED

Total Score \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Chiropractic Services**

**By reading below I have been made aware:**

1. The process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually, with a table mechanism, or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies and/or Procedures" may be applied by the chiropractor or by staff under the chiropractor's direction or supervision incorporating the use of vibration, electricity, traction, motion, and/or nutritional advice;
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

**Additionally:**

1. I have been afforded ample opportunity for questions and answers.

**Therefore by signing below:**

**I consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

**I consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Eastern Oklahoma Chiropractic, PLLC    D.B.A.: Eastern Oklahoma Chiropractic  
Pinnacle C.O.P. Manual-1.0  
Revised 10.15.2014

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

**AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above.

**AUTHORIZATION FOR X-RAY WITH RELEASE:** By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

**ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:** By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

**CMS-1500 HEALTH INSURANCE CLAIM FORM:** By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

**ACKNOWLEDGEMENT OF TREATMENT PLAN:** By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

**ACKNOWLEDGEMENT:** By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS OF ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

# Eastern Oklahoma Chiropractic

6922 South Lewis Avenue

Tulsa, OK 74136

Phone: (918) 935-3432

Fax: (918) 935-3433

## Non-Covered Services Statement

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Eastern Oklahoma Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Eastern Oklahoma Chiropractic the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay Eastern Oklahoma Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim. I authorize Eastern Oklahoma Chiropractic to ASSIGN ALL

BENEFITS payable directly to Eastern Oklahoma Chiropractic. I understand that my financial arrangements are made directly with Eastern Oklahoma Chiropractic and not with the insurance company, third party insurance, or attorney. I understand that medical liens will be filed at the Tulsa's County Courthouse with my name on them. This is standard practice for all auto cases and an office policy of Eastern Oklahoma Chiropractic. It is my responsibility to pay for the courthouse lien fees as well as the lien release, unless I have made other arrangements with Eastern Oklahoma Chiropractic. I agree to give a copy of my insurance card to accurately file my insurance claims. I understand that if in the rare situation that any monies that have been overpaid to Eastern Oklahoma Chiropractic I would be granted a check of the difference.

## Acknowledgement of Receipt of Notice

I hereby acknowledge that I have access to a copy of the Notice of Privacy Practices (HIPPA).

## Consent of Professional Service & Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, X-rays studies, laboratory procedures, chiropractic care, or any clinic services that he/she deems necessary in my case; I further authorize him to disclose all or any part of my record to any person or employer of the patient, including, and not limited to, hospital or medical service companies, insurance companies, workers compensation carriers, welfare funds or the patient employer.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

For office use only:

- Signed form received by: \_\_\_\_\_
- Acknowledgment of refusal: \_\_\_\_\_
- Reason for refusal: \_\_\_\_\_