CONFIDENTIAL PATIENT CASE HISTORY

Cell #:

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
THANK YOU.

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Age _____ Birthdate _____ Marital Status: M S W D

Work Telephone _____ # Children _____ Spouse's Name _____

Occupation _____ Referred by _____ Spouse's Office Telephone _____

HEALTH INFORMATION

Have you had previous chiropractic care? _____

What is your major complaint? _____

_____

Other complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other _____

How long has it been since you really felt good? _____

Other doctors who treated this condition: _____

_____

List surgical operations and dates: _____

_____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers
☐ Insulin ☐ Birth control pills ☐ Others _____

Age of mattress: _____ ☐ Comfortable ☐ Uncomfortable

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe: _____

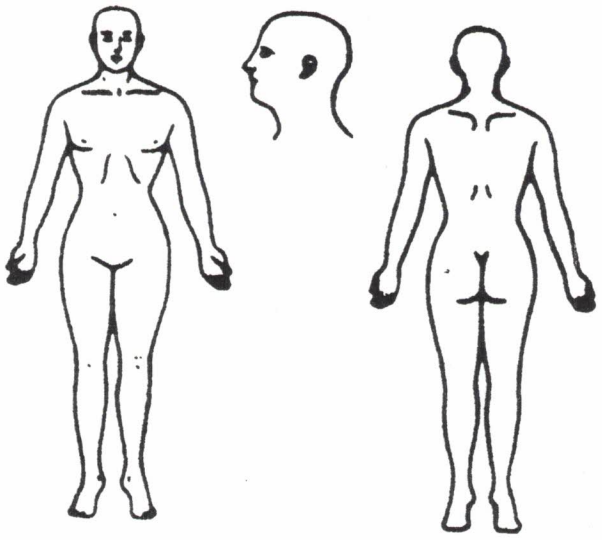
Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years
☐ None

Describe: _____

Is it possible you may be pregnant? ☐ Yes ☐ No

Date of Last Physical Examination _____

Please mark your areas of pain on the figures below.



Have you Ever Suffered From:

1. Dizziness ..... ☐ Yes ☐ No
2. Backaches ..... ☐ Yes ☐ No
3. Heart Trouble..... ☐ Yes ☐ No
4. Diabetes ..... ☐ Yes ☐ No
5. Arthritis ..... ☐ Yes ☐ No
6. Headaches ..... ☐ Yes ☐ No
7. Asthma ..... ☐ Yes ☐ No
8. Neuritis ..... ☐ Yes ☐ No
9. Digestive Disorders ..... ☐ Yes ☐ No
10. Nervousness..... ☐ Yes ☐ No
11. Sinus Trouble ..... ☐ Yes ☐ No
12. Neck Pain ..... ☐ Yes ☐ No

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____ Yes _____ No

Do you have Health Insurance? _____ Yes _____ No

If yes, Name of Company _____ Policy # _____

Are you covered by Medicare? _____ Yes _____ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date _____

Guardian or Spouse's Signature: _____ S.S. # _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION. (Many health problems are the result of hereditary spinal weakness; thus information about your family members will give us a better picture of your total health.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

PATIENT INTAKE FORM

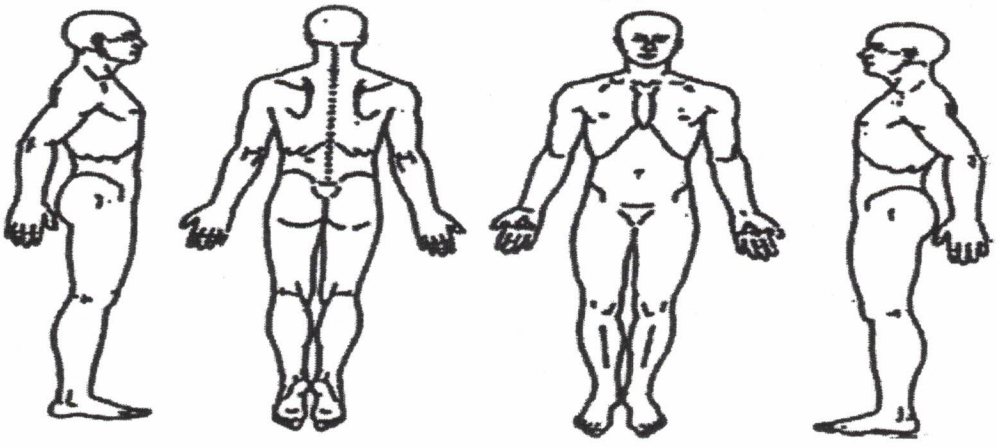
THE OAKCHUNAS CHIROPRACTIC CLINIC, L.L.C.--DR. LEO A. OAKCHUNAS

**Legend: N=neck, T=upper/mid back, Lo=lower back, A=arm, Leg=leg, L=left, R=right

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

Patient Name: _____ Date: _____

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

Patient Name: _____ Date: _____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

THE
OAKCHUNAS
CHIROPRACTIC
CLINIC, L.L.C.

Dr. Leo A. Oakchunas

310 East Broad Street · Bethlehem, PA 18018 · 610-849-0779 · FAX 610-849-0824

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subjected to redisclosure by anyone who has access to the remainder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of_____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Name Printed **Date**

_____ _____

Patient Signature **Authorized Provider Representative**

_____ _____

Personal Representative Printed **Personal Representative Signature**

_____

Description of Personal Representative's Authority to Act for the Patient

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Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ _____

Printed Name **Authorized Provider Representative**

_____ _____

Signature **Date**