Inspired Health Chiropractic Case History

CONFIDENTIAL PATIENT INFORMATION DATE _____

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital: M☐ S☐ W☐ D☐ How Many Children? _____

Occupation _____ Employer _____

Student _____ Full-Time: _____ Part-Time: _____

Address _____ Office Phone _____

Name of Husband/Wife _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone Number _____

Referred by: _____(We want to send them a thank-you!)

Is your condition due to an injury or illness arising out of employment? _____

Is your condition due to an injury or illness arising out of an auto or other accident? _____

Have you ever had the same or similar condition? YES____ NO_____

If YES, when and describe: _____

Name of Primary Care Physician _____ Phone _____

Date of last physical exam _____Results? _____

I understand and agree that health and accident insurance policies are an agreement between my insurance company and me – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual or customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay the percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Signature _____ Date _____/_____

Reason for Visit

Main complaint: _____

1. When did it start? _____
2. Did it begin: Gradually ☐ or Suddenly ☐ If gradually, how long did it take to develop? _____
3. Did anything cause or contribute to the onset? _____
4. Have you ever had anything like this before? YES ☐ NO ☐ If YES, did it feel the same? _____
5. Can you describe the exact location of the symptoms? _____
6. Does it travel/radiate to any other part of your body? _____
7. Do you have symptoms in any other part of your body? _____
8. Can you describe the pain/sensation? Check all that apply: Achy ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Burning ☐ Stabbing ☐ Other_____
9. How frequently does it occur? Constant ☐ Come and Go ☐
10. Has it been getting worse? YES ☐ NO ☐ Same ☐ Better ☐ Gradually Worse ☐
    If YES, when and how? _____
11. Does anything make it better? YES ☐ NO ☐
    If YES, describe: _____
12. Does anything make it worse? YES ☐ NO ☐
    If YES, describe: _____
13. Has there been any change in bodily functions (urination, bowel or sexual function)? YES ☐ NO ☐
14. Has it affected your daily activities? YES ☐ NO ☐
    If YES, describe: _____
15. Have you tried store bought or home remedies? YES ☐ NO ☐
    If YES, describe: _____
16. Have you sought other professional care for this condition? YES ☐ NO ☐
    If YES, describe: _____
17. Remarks: _____
18. What is the pain intensity? Mild ☐ Moderate ☐ Severe ☐

No Symptoms Extreme Symptoms

|_____|

0 Please place an "X" on the line above to indicate your pain level 10

Medical History

Please note if you or an immediate family member are currently or have ever experienced any of the below diseases:

Illness	You	Relative	Illness	You	Relative
Cancer	☐	☐	Tuberculosis	☐	☐
Hepatitis	☐	☐	Diabetes	☐	☐
High Blood Pressure	☐	☐	Heart Disease	☐	☐
Rheumatic Fever	☐	☐	Stroke	☐	☐
MRSA	☐	☐	Seizures	☐	☐
HIV	☐	☐	Emotional Disorders	☐	☐

Do You Currently Have Any Infectious Diseases? YES ☐ NO ☐ If YES, What Disease?_____

Do You Have Any Known Allergies? YES ☐ NO ☐ If YES, To What? _____

Are You Taking Coumadin or Warfarin? YES ☐ NO ☐ Do You Have A Pacemaker? YES ☐ NO ☐

Please list any medications (prescribed or over the counter), vitamins, supplements, or herbs you are currently taking

Medication	Dosage	Reason	How Long	Prescribed By
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Blood Pressure: _____/_____ Month And Year Blood Pressure Was Last Checked: _____/_____

Men Only

Date Of Last Prostate Check Up: _____/_____/_____

Please Check Any Symptoms That You Experience:

Erectile Dysfunction (ED) ☐ Groin Pain ☐ Delayed Urinary Stream ☐

Post Void Dribbling ☐ Increased Libido ☐ Testicular Pain ☐

Decreased Libido ☐ Premature Ejaculation ☐ Decreased Force Of Stream ☐

Retention Of Urine ☐ Genital Pain ☐ BPH/Enlarged Prostate ☐

Genital Discharge ☐

Women Only

Are You Or Could You Be Pregnant? YES ☐ NO ☐ If YES, How Far Along Are You? _____

Of Pregnancies: _____ # Of Live Births: _____ # Of Abortions: _____ # Of Miscarriages: _____

Date Of Last Gynecological Exam: _____/_____ Date Of Last Pap Smear: _____/_____

Date Of Last Mammogram: _____/_____ Age Of First Period: _____

Age Of Last Period: _____ Number Of Days Between Period: _____

Number Of Days Of Flow: _____ Color Of Blood: _____

Do You Have Clots In Your Flow? YES ☐ NO ☐ If YES, What Size Are The Clots:_____

Do You Have Heavy Flow? YES ☐ NO ☐ Do You Have Light Flow? YES ☐ NO ☐

Have You Been Diagnosed With Any Of The Following (Please Check Any That Apply):

Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ Pelvic Inflammatory Disease ☐

Please Check Any Symptoms That You Experience:

Vaginal Discharge ☐ Hot Flashes ☐ ↑ Libido ☐ ↓ Libido ☐

Premenstrual Mood Swings ☐ Premenstrual Nausea ☐ Premenstrual Swollen Breasts ☐

↑ Hunger Before Period ☐ Poor Appetite After Period ☐ Poor Appetite Before Period ☐

↑ Hunger After Period ☐ Headache Before Period ☐ Headache During Period ☐

Constipation/Diarrhea Before Period ☐ Constipation/Diarrhea During Period ☐ Vaginal Dryness ☐

Lifestyle

Please indicate the use and frequency of the following:

	YES	NO	HOW OFTEN		YES	NO	HOW OFTEN
Coffee/Black Tea	☐	☐	_____	Water	☐	☐	_____
Recreational drugs	☐	☐	_____	Pop	☐	☐	_____
Tobacco	☐	☐	_____	Alcohol	☐	☐	_____
Exercise	☐	☐	_____				

Do You Typically Eat Three Meals A Day? YES ☐ NO ☐ If NO, How Many? _____

How Many Hours Per Night Do You Sleep? _____ Is It Easy For You To Fall Asleep? YES ☐ NO ☐

Do You Wake Up During The Night? YES ☐ NO ☐ Do You Easily Fall Back Asleep? YES ☐ NO ☐

Do You Wake Up Feeling Rested? YES ☐ NO ☐

How Many Hours Per Week Do You Work? _____ Do You Enjoy Work? YES ☐ NO ☐

Wellness Goals

What Are Your Goals For Health? (Example: decrease pain; increase joint mobility etc.)

_____
_____
_____
_____

What Is One Activity You Would Like To Be Able To Do Again? (Example: running)

_____

How Happy/Fulfilled Do You Feel?

Not Happy/Fulfilled — Very Happy/Fulfilled

What Types Of Therapies Are You Interested In? Check All That Apply:

Chiropractic ☐	Massage ☐	Nutrition ☐	Acupuncture ☐
Energy Therapy ☐	Cupping ☐	Posture Retraining ☐	Stretches/Exercises ☐
Hormone Balancing ☐	Yoga ☐	Meditation ☐	Emotional Support ☐

Patient Signature_____ Date_____

Doctor Signature_____ Date_____

Inspired Health Chiropractic Informed Consent

The state of Michigan requires every patient to be informed of the risks of treatment and the alternatives to treatments prior to the beginning of care. We intend this consent form to cover the entire course of treatment for you present condition and for any conditions for which you see treatment at this clinic.

The nature of chiropractic treatment. The doctor will use her/his hands or mechanical device in order to adjust/manipulate your joints. You may hear a audible sound, similar to when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as hot/cold packs, cupping, topical analgesic with essential oil, nutrition, traction, exercise and stretching instruction may also be used.

Possible risks and probability. There are inherent risks in my and all treatment derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustments/manipulations. The risk is very minor to non-existent in any treatment of the extremities. A list from the least to the most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral disc, nerves or spinal cord (very rare). The risk involved in the treatment of the neck would include any of the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very rare; incident rate is one in ten million). A minority of patients may notice stiffness or soreness after the first few days of treatment (common). The ancillary procedures could produce skin irritations or other minor complications (rare).

Other treatment options, not provided by this clinic, which could be considered, may include the following:

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

Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which include death), as well as extended convalescent period in a significant number of cases.

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

Concerns or questions, please ask your Doctor of Chiropractic. Dr. Jasmine Hornberger and the staff at Inspired Health Chiropractic have gone great lengths to make your health and safety a top priority. Dr. Jasmine will be glad to discuss any concerns about your treatment protocol. Suffice to say, we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic care. I also had the opportunity to ask questions and have them 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 hereby give my full consent to treatment.

Printed Name_____ Signature_____ Date_____

Financial Responsibilities

Thank you for choosing Inspired Health Chiropractic as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare.

We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patients guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We are pleased to assist you by billing our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any changes incurred if the information provided to us in not correct or updated.
- Patients are responsible for co-pays, co-insurance, deductibles, and all other procedures or treatment if not covered by their insurance plan.
- All payments are due at time of service, and for you convenience, we accept cash, check, and most major credit cards.
- Patients may incur, and are responsible for the payment of additional charges.
  These charges may include (but are not limited to):
    - Charge for missed appointments without 24 hours advance notice
    - Charge for after hours appointments including diagnosis, treatment etc
    - Charge for copying and distribution of your records
    - Any costs associated with collection of patient balances

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____

Signature of patient or guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at time of service and/or to be fully responsible for payment charges and to submit claims to insurance at my discretion.

_____ _____

Signature of patient or guardian Date