Tessendorf
FAMILY CHIROPRACTIC

Patient Case History

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ ex: _____

Cell Phone: _____-_____-_____ Date of Birth: _____

Email Address: _____ Occupation: _____

How did you hear about us? _____

Gender: Male - Female

What is your major complaint? _____

Date problem began? _____

How did this problem begin? (falling, lifting, etc.) _____

How is your condition changing? Getting Better Getting Worse Not Changing

Have you had this condition in the past? Yes No

How often do you experience your symptoms in a day?

Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

Describe the nature of your symptoms: Sharp Dull Numb Burning Shooting Tingling

Radiation Pain Tightness Stabbing Throbbing Other: _____

Please rate your pain on a scale of 1 to 10: (0 = no pain to10 = excruciating pain) _____

How do your symptoms affect your ability to perform daily activities? (working, driving, etc.)

(0 = no effect and 10 = no possible activities) _____

What activities aggravate your condition? (working, exercise, etc.)

_____

What makes your pain better? (ice, heat, massage, etc.)

_____

Any other issues you would like to discuss? _____

Review of Systems

Do you have any of the following?

Skin, Hair, or Nail problems	Swollen Extremities	Urinary Problems	FatigueEye Problems
Weight Change (unplanned)	Swallowing Issues	Dizziness/Vertigo	Weakness
Ear Problems	Menstrual Problems	Digestive Issues	Sinus/Allergies
Heartburn/Indigestion	Bowel Issues	Breast Pain	Abdominal Pain
Heart Problems	Clumsiness	Other: _____	

Past Medical History

Have you had chiropractic care before? Yes No When? _____

Have you had these symptoms before? Yes No When? _____

Are your symptoms? Improving About the Same Getting Worse Intermittent (comes and Goes)

Who is your family medical doctor? _____

List all hospitalizations and surgical operations: _____

_____

List all prescription medications: _____

_____

List all non-prescription medications/supplements: _____

_____

What are your habits? Tobacco Alcohol Caffeine

What is your exercise activity level? None Light Moderate Strenuous

What is your stress level? None Minimal Moderate Great

What is your physical activity level?

Sitting 50% of the Time Light labor Manual labor Repetitive motions Heavy labor

Please indicate any conditions you have been treated for:

High Blood Pressure	Epilepsy/Seizures	Sinus/Allergy Issues	Heart Issues	Liver Issues
Low Blood Pressure	Lung Problems	Thyroid Issues	Stroke	Kidney Issues
Spinal Disc Disease	Cancer/Tumor	Numbness Groin or Buttocks		Fainting
Aortic Aneurysm	Breast Issues	Mental/Emotional Issues		Pacemaker
Vertigo	Diabetes	Abnormal Weight Change		Arthritis
Menstrual Issues	Osteoporosis	Visual Issues	Scoliosis	Prostate Issues

Bone Fractures – list with dates: _____

Other: _____

List any allergies: Animals Aspirin Bees Chocolate Dairy Dust Eggs Latex Molds Penicillin Ragweed/Pollen Rubber Seasonal Allergies Shellfish Soaps Wheat X-Ray Dye Other: _____

Family Medical History

Please indicate which family member had what issues below

Arthritis High Blood Pressure Cancer Diabetes Stroke Osteoporosis Parkinson's Cardiovascular Issues Polio Asthma Back Pain Epilepsy Multiple Sclerosis Neurological Problems Genetic Spinal Condition Other

Father: _____

Mother: _____

Brother: _____

Sister: _____

Grandfather: _____

Grandmother: _____

Functional Assessment

Please indicate what activities aggravate your symptoms below

Sitting Lifting Dressing Sleeping Standing Driving Walking Squatting Reaching Kneeling Grooming Bending Hobbies Pet Care Yard Work Carrying Small/Large Objects Putting on Shoes Pulling things while Standing Extended Computer Use Pulling thins while Sitting Reaching Overhead Household Chores Going up/down Stairs Lifting Objects off Floor Lifting Objects off Table Caring for Family Standing/Sitting for Long Periods of Time Other: _____

Minimal (forget when performing): _____

Slight (infrequent breaks): _____

Moderate (frequent breaks): _____

Severe (can NOT perform): _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spine column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specialized in that area.

Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Patient Signature Date

Financial Policy (Revised 7/23/2013)

PATIENTS WITH HEALTH INSURACE: The patient's insurance company will be billed promptly according to our standard fees and based on the services provided. We expect to collect your co-pay, co-insurance and/or deductible at the time the services are rendered. Time-of-service discounts are exempt if we are billing your insurance plan.

PATIENTS WHO CHOOSE PAY OUT-OF-POCKET: Payment for all services is expected and appreciated at the time of service. We have developed a 'time-of-service' discount for cash patients or patients who choose not to use their health insurance (due to high deductible, or deductibles not met). The time-of-service discount will reduce the price of all services rendered if they are paid for on the day of service. We graciously accept cash, check, debit and most credit cards, as well as care credit. We do not barter or trade services. Any services not paid for on the day of service will be billed to the patient at our normal rate; non- payment on these services will result in attempts to collect the debt owed. Debts not paid in a timely manner may be subject to professional debt collection if necessary.

PATIENTS WHO ELECT NOT TO USE THEIR INSURANCE: We will consider you an out of pocket patient (as explained above) for the time being and will not bill your insurance company for the services rendered; however you may use your insurance at any time if you so choose. You may elect to take advantage of our time-of-service discount, however for that to apply all services rendered must be paid for at that time. If you choose not to take advantage of this discount, you will be billed at our normal rates. If you meet your deductible and would like your bills retroactively sent to your insurance provider we can do this for you; however we will then bill at our normal rate and you may be responsible for the difference.

PERSONAL INJURY PATIENTS: We will bill your health insurance or motor vehicle insurance company at our normal rates. Some insurance companies will require the patient to choose which policy (health insurance or vehicle insurance) they want to bill. It is not our policy to carry balances on Personal Injury Accounts if you choose to bill the adverse party's insurance company; you will be required to pay for services at the time the services are rendered.

ALL PATIENTS: Payment is due upon receipt unless further arrangements are made (e.g. monthly billing statements). If your account with us remains un-paid for more than one month (30 calendar days) a bill will be mailed to you for the balance due; it is the patient's responsibility to pay this debt. If the balance remains unpaid for more than three months (90 calendar days) a professional debt collection service will be utilized to recover the balance owed by the patient, unless re-imbursement arrangements are made by the patient.

MISSED APPOINTMENTS: Missed appointments will be charged at a rate of $10.00 per person per missed appointment. To avoid these charges simply call and reschedule if you know that you will be truant. Charges will be made to the patients account and collected at the next service date. Reminder calls are available if you tend to forget appointment dates, please ask our receptionists to give you a call in the future.

If you have any questions about our financial policy, please ask us before you sign this.

_____

Print Patient Name (Last, First, Middle Initial)

_____

Patient Signature Date

_____

Parent/Guardian Signature (if patient is under 18) Date

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Consent to Chiropractic Care

Doctors of Chiropractic are skilled healthcare providers who specialize in diseases and disorders of the spine and nervous system. Chiropractors use their skills to assess, locate and adjust the bones of the spine or appendicular skeleton in order to safely and effectively provide for better articulation, range-of-motion and as a result reduce inflammation, edema and nerve interference. In doing so Doctors of Chiropractic work to provide their patients with a hands-on healthcare experience that is catered towards natural or holistic ideals. Doctors of Chiropractic do not prescribe prescription or over-the-counter medications, they do not perform surgery and they do not provide vaccinations.

Chiropractic care, though incredibly safe in most cases, can like many other modalities of healthcare, carry the risk of complications; patients may have adverse reactions to Chiropractic care and may be unsatisfied as a result. Although these cases are rare, it is important to note that there is a potential for sore musculature, mild bruising, headache, and in rare events fractured bones (most often ribs) and transient ischemic attack or stroke. The likelihood of stroke is skewed by inconsistent research [1 in 1 million to 1 in 10 million]. The likelihood of stroke is multiplied several-fold by poor lifestyle choices, being over-weight, having high blood pressure or high [bad] cholesterol levels, or high stress levels. Doctors of Chiropractic take care to evaluate each patient for these risks and perform examinations as they see fit in an effort to rule out the potential for a transient ischemic attack.

I have read the aforementioned statement and understand that there are risks inherent with Chiropractic care, and have made the Doctor of Chiropractic aware of any concerns I have with beginning Chiropractic care and have given the Doctor of Chiropractic the opportunity to address these concerns. I have freely decided to undergo Chiropractic care, will abide by the recommended treatment plan provided by the Doctor of Chiropractic and hereby give my full consent to care.

_____	_____	_____
Printed Name	Signature	Date

CONSENT FOR TREATMENT OF MINORS

The undersigned parent/guardian of _____ born on_____

Does hereby empower and grant Tessendorf Family Chiropractic LLC and/or affiliates permission to authorize Chiropractic care and/or x-rays for the aforementioned child.

This authorization shall be valid for the period of time from: _____ ending _____. I hereby release and hold harmless the Chiropractors, clinic and other persons who act in reliance upon this authorization from all liability in performing any Chiropractic care which they, in their sole discretion, deem necessary.

Parent/Guardian name:_____

Signature:_____ Date:_____

CLINIC USE ONLY

Telephone consent: _____

_____ Witness _____ Date _____ Time

_____ Witness _____ Date _____ Time

HIPAA AUTHORIZATION

From time to time our practice would like to make you aware of products, services and information that you may have an interest in. We are specifically requesting authorization to market the following products and/or services to you:

You may restrict this release or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. 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.

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

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

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 other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave voice/text messages on your phone or with individuals at your home or place of employment.

You have the right to refuse to give us this 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.

Print Patient Name	Date
Patient Signature	Authorized Provider Representative

Authorization to release medical information, appointment information and account information to the following:

1. _____ 2. _____

3. _____ 4. _____