Date ______________________

Your Case History

Name ______________________ Home Phone ____________ Work Phone ____________

Cell Phone ____________ Email ______________________

Mailing Address ______________________ City ____________ State ______ Zip Code ______

Date of Birth ______________________ Social Security Number ____________

Employed by ______________________ Occupation ____________ How long ______

❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse's Name ______________________

Children's names and ages ______________________

Payment preference: ❑ Cash ❑ Check ❑ Bank Card ❑ Care Credit (on available credit)

If insured, which insurance company will you be billing? ______________________

Policy number ______________________ Insurance company phone (_____) ____________

Who referred you to our office? ______________________

What can we help you with?

Check all that apply

- ❑ Optimum performance and wellness lifestyle
- ❑ General return to good health
- ❑ Subluxation detection and correction
- ❑ Specific complaint (Please describe) ______________________

____

If you are experiencing pain, is it: ❑ Sharp ❑ Dull ❑ Burning ❑ Achy ❑ Stiff ❑ Comes and goes
Check all that apply ❑ Constant ❑ Radiating ❑ Mild ❑ Moderate ❑ Severe

Others consulted for the same or similar health challenge ______________________

If injured, please briefly describe date and nature of onset ______________________

____

How does your health challenge affect your:

Work ______________________

Relationships ______________________

Play Time ______________________

Please rate the following statements from 1 to 10. 1 is the lowest, 10 is the highest.

The healthiest you have ever been in your life ______

Your current level of health ______

Your desire for a lifetime of health ______

Tahoe City Chiropractic

"Optimum Care for your Active Lifestyle"

Dis-ease Process

Answer these questions as they relate to **Your Childhood History**

	YES	NO	MAYBE
Did you fall while learning to walk?	❑	❑	❑
Did you play any contact sports?	❑	❑	❑
Any physical trauma as a child?	❑	❑	❑
Did you have any falls as a child?	❑	❑	❑
Were you picked on by siblings?	❑	❑	❑
Any emotional trauma as a child?	❑	❑	❑
Were/are you exposed to second hand smoke?	❑	❑	❑
Did you use over the counter drugs?	❑	❑	❑
Did you use prescription drugs as a child?	❑	❑	❑
Any car accidents as a child?	❑	❑	❑
Were you vaccinated?	❑	❑	❑
Any allergies as a child?	❑	❑	❑
Did you have frequent colds as a child?	❑	❑	❑
Were you under chiropractic care as a child?	❑	❑	❑
Did you eat a healthy diet as a child?	❑	❑	❑
Did you have any other accidents?	❑	❑	❑

Answer these questions as they relate to **Age 18 or over**

	YES	NO	MAYBE
Have you had any surgery?	❑	❑	❑
Have you had any car accidents?	❑	❑	❑
Have you ever fallen on the ice/snow?	❑	❑	❑
Do/did you lift small children?	❑	❑	❑
Do you sleep well?	❑	❑	❑
Do you lift heavy weights?	❑	❑	❑
Do you use prescription drugs?	❑	❑	❑
Do you use over the counter drugs?	❑	❑	❑
Do you drink alcohol?	❑	❑	❑
Have you had any wild slips or falls?	❑	❑	❑
Have you fallen off a bike?	❑	❑	❑
Is your bed adequate and up to date?	❑	❑	❑
Do/did you smoke?	❑	❑	❑
Do you watch your posture?	❑	❑	❑
Do you sit excessively?	❑	❑	❑
Have you had any other accidents?	❑	❑	❑

Please check any symptom that you have ever experienced

- ❑ Headaches
- ❑ Visual changes
- ❑ Ear infections
- ❑ Pain in ears
- ❑ Loss of hearing
- ❑ Sinus infection
- ❑ Frequent colds/flu
- ❑ Stiff neck
- ❑ Asthma
- ❑ Leg pain on exertion
- ❑ Leg pain at rest
- ❑ Pain after eating
- ❑ Pain relieved by eating
- ❑ Constipation
- ❑ Change in stool color
- ❑ Frequent urination
- ❑ Difficult urination
- ❑ Bladder infection
- ❑ Premenstrual syndrome
- ❑ Menstrual cramps
- ❑ Irregular menstrual cycles
- ❑ Arthritis
- ❑ Diabetes
- ❑ Cancer
- ❑ Bone infection
- ❑ Osteoporosis
- ❑ Fracture of bone
- ❑ Rheumatic fever
- ❑ Weight loss
- ❑ Fatigue
- ❑ Anemia
- ❑ Neck Pain
- ❑ Neck feels out of place
- ❑ Limited motion in neck
- ❑ Mid back pain
- ❑ Muscle spasm in back
- ❑ Loss of motion in mid back
- ❑ Low back pain
- ❑ Sciatica
- ❑ Loss of motion in low back
- ❑ Muscle spasm in low back
- ❑ Numbness in hands/arms
- ❑ Numbness in feet/legs

Family Health History Please list all concerns

Children ______________________

Mother ______________________

Brothers ______________________

Grandparents ______________________

Spouse ______________________

Father ______________________

Sisters ______________________

Others ______________________

Health Process

	YES	NO	MAYBE
Do you get good rest?	❑	❑	❑
Do you eat quality food?	❑	❑	❑
Do you exercise properly?	❑	❑	❑
Do you drink quality water?	❑	❑	❑
Do you get along with friends and family?	❑	❑	❑
Do you get regular spinal adjustments?	❑	❑	❑

I agree to allow this office to examine me to determine if I am eligible for chiropractic care. I further agree that the primary purpose of my relationship with this office is my desire to pursue the detection and correction of my chiropractic subluxations. *I agree to keep an open line of communication with this office and I will do my best to maintain a healthy lifestyle.*

SIGNATURE DATE PARENT OR GUARDIAN (IF UNDER 18 YEARS)

Patient Name____

Birth Date ____

INFORMED CONSENT: CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or the patient named above, for whom I am legally responsible) by Dr.Schroeder and/or his office staff who may now or in the future treat me in this office.

I have had an opportunity to discuss with the doctor and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

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, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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 as the known, is in my best interests.

I have read, or have 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 procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any other future condition(s) for which I seek treatment.

____

Patient/Guardian Signature Date

____

Doctor's Signature Date

____

Witness Signature Date

Consent for Release of Protected Health Information and Acknowledgement of Receipt of Privacy Practices

I consent to the use or disclosure of my protected health by Tahoe City Chiropractic (TCC) for the purposes of providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of TCC. **I understand that diagnosis or treatment of me by any practitioner associated with TCC may be conditioned upon my consent as evidence by my signature on this document.**

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. TCC is not required to agree to the restrictions that I may request. However, if TCC agrees to a restriction that I request, the restriction is binding to TCC on any practitioner associated with TCC.

I have the right to revoke this consent, in writing, at any time, except to the extent that TCC or any practitioner associated with TCC has taken action in reliance on this consent. I understand, however, that doing so will result in immediate termination of my status as a patient at TCC, as my signature on this document is a condition of treatment here.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review this office's Notice of Privacy Practices (NPP) prior to signing this document. TCC's NPP has been offered to me for my review. The NPP describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of TCC. The NPP also describes my rights and TCC's duties with respect to my protected health information.

TCC reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

In our office chiropractic adjustments are generally performed in an open environment. Every attempt will be made to protect your health care information. It is possible that conversations with the doctor may overheard or written information may be incidentally noted. We do make every effort to protect your privacy. **If you desire a private room for health care conversation or treatment we will provide you with one at your request.**

My signature below indicates that I have read and understand the above and agree to its provisions. It further acknowledges that I have been given a copy of the NPP.

______________________________ Date______________

Signature of Patient or Personal Representative

______________________________ ______________________________

Name of Patient or Personal Representative   Authority of Personal Representative