Beason Wellness Patient Case History

Name____ Sex M F Date__________________

Address____ City________________________ State_____ Zip________

H. Phone __________________________ C. Phone______________________ Email_______________________________

Age_____________Date of Birth_________________ Height___________________ Weight_________________________

Referred by____Social Security #_________________________________

Occupation____ Employer_______________________________________

Have you ever received Chiropractic/Alternative Health Care? Yes No when? __________________________________

1. Primary reasons for seeking care:

Primary reason: ____

Secondary reason: ____

Other factors contributing to the primary and secondary reasons: ____

2. Chief Complaint: ____

Location of Complaint: ____

Complaint Began when and how? ____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _______

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? ____________________________________

Do you have any numbness or tingling in your body? Where? ____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? ____

Does anything aggravate the complaint? ____

Does anything make the complaint better? ____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _________________

____

____

4. Past Health History:

A. Illnesses/Medical conditions you currently have or have had in your life:____

____

B. Previous injury or trauma: ____

____

Have you ever broken any bones? Which? ______________________________

C. Allergies ______________________________

D. Medications:

Medication	Reason for taking

E. Surgeries:

Date	Type of Surgery

F. Females:

Pregnancies/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? ______________________________

5. Family Health History:

Associated health problems of relatives: ______________________________

____

Deaths in immediate family:

Cause of parents or siblings death	Age at death

6. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description: ______________________________

C. Work schedule: ______________________________

D. Recreational activities: ______________________________

____

E. Exercise (type, frequency and duration):____

____

F. Alcohol (amount, frequency, years of sobriety):____

____

G. Tobacco (amount, duration, year of quitting):____

____

H. Recreational Drugs (type, amount, duration, year of quitting):___________________________

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Please go to next page…

Authorization for Care, Informed Consent, Assignment of Insurance Benefits for Direct Payment to Doctor and Office Policies

I hereby request and consent to the performance of chiropractic adjustments and/or other chiropractic procedures, including various modes of physical therapy, lifestyle and nutritional recommendations, and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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 I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The Doctor will not be held responsible for pre-existing medically diagnosed conditions nor for any medical diagnosis.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and a policyholder. I authorize the Doctor's office to release all information necessary to communicate with personal physicians and other healthcare provides and payers to secure the payment of benefits. I understand that any amount authorized to be paid to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my dependents or me.

We want you to know how you to know how your patient health information is going to be used in this office and your rights concerning those records.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPAA Notice that is available to you before signing this consent.

If there is anyone you do not want to receive your medical records, please inform our office.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

All appointments not cancelled within 24 hours will be charged at the regular office fee. Monday appointments must be cancelled on the Friday previous to the Monday appointment.

Patient Signature____Date________________________

Parent or Guardian Signature ____ Date ________________________

Doctors Signature ____ Date ________________________