CONFIDENTIAL PATIENT CASE HISTORY

All fields in top section are required

*Last Name: _____ *First Name: _____

*Address: _____ *City: _____ *State: _____ *Zip:_____

*Home Phone: _____ *Cell Phone: _____

*Occupation: _____ *Work Phone: _____

*Sex: M F *Birthdate: _____ *Age: _____ *Marital Status: M S W D

*Social Security #: _____

*E-Mail: _____

*Emergency Contact & Telephone: _____

How did you hear about Washington Injury and Sports Performance Clinic?

_____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic employed at WISPC and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for my doctor, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and 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, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I 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 then known, and is in my best interests.

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 conditions for which I seek treatment.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

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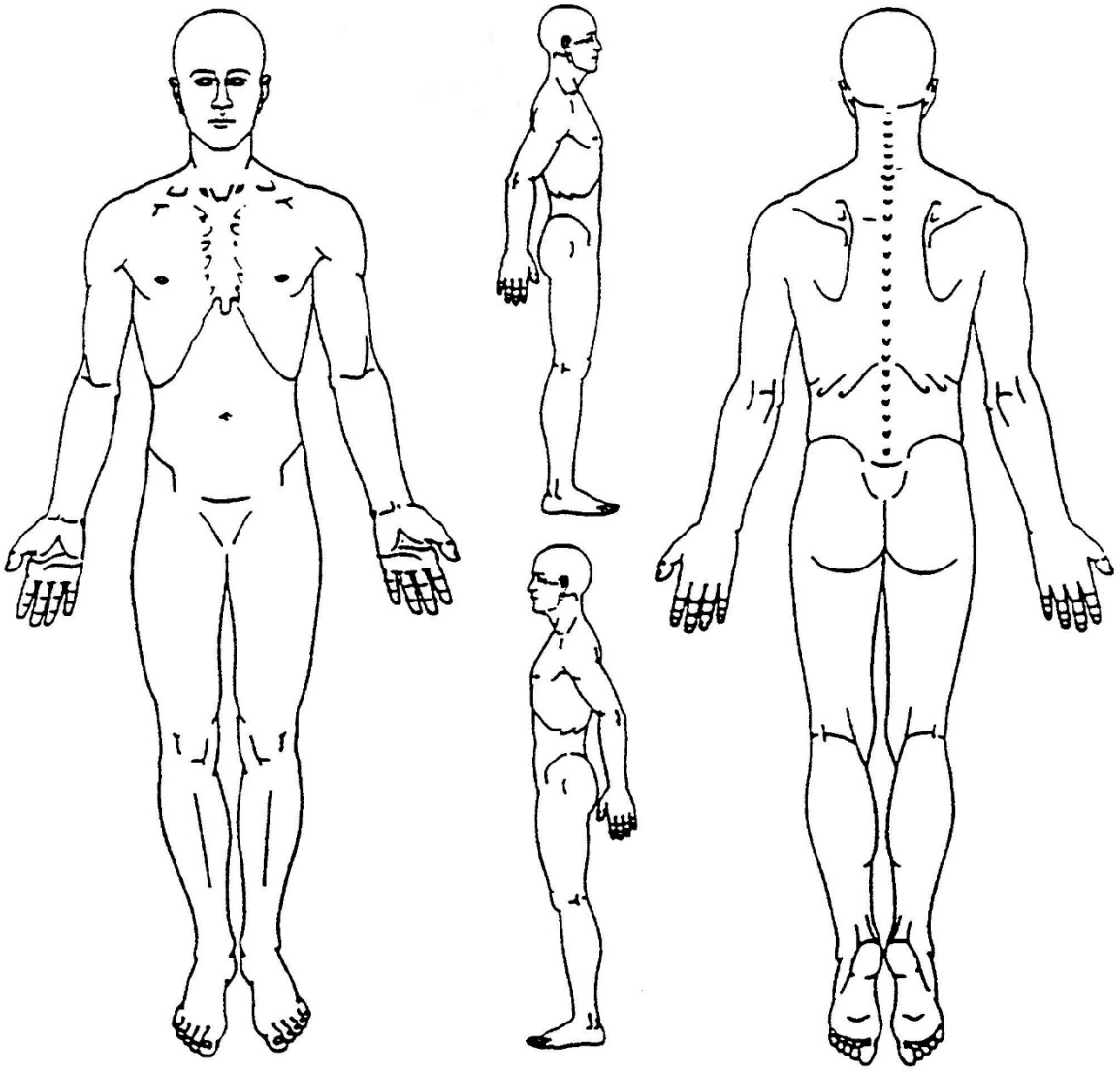
PAIN DRAWING

Please mark the figure below with the letters and best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, ←, or → to indicate the direction of radiating pain.

A = Ache	D = Dull Pain	P = Pins & Needles	SH = Shallow
B = Burning	N = Numbness	T = Throbbing	C = Cold
R = Radiating Pain	S = Stabbing	DP = Deep	O = Other



Please circle how you would rate your pain RIGHT NOW:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Please circle how you would rate your AVERAGE pain:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Please circle both the pain level at its BEST and at its WORST: (circle two numbers)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Name (please print): _____ Date: _____

Signature: _____

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COMPLAINT

What is your major/presenting complaint? (please provide an exact description) _____

_____

_____

What is the location of the complaint? _____

When did the pain begin? _____

Is the pain constant (all day long, no relief)? □ Yes □ No

Does the pain come and go? □ Yes □ No If yes, how frequent is it? (E.g. times per day or week)

_____

Was there a precipitating event? □ Yes □ No If yes, what?

_____

What makes the condition worse? _____

What makes the condition better? _____

Do you have a history of similar conditions in the past? □ Yes □ No If yes, when? _____

Is the condition getting: □ Worse □ Same □ Better

Is there a particular time of day when your condition is worse? □ Morning □ Afternoon □ Evening □ Night

Have you had other examination and/or treatment of this problem? □ Yes □ No

If yes, when? _____ By whom? _____

Have you had any associated symptoms, such as: (circle any that apply)

Unexplained weight loss	Infection	Dizziness
Loss of bladder or bowel control	Fever or Chills	Ringing in the ears
Pain that wakes you up during sleep	Persistent swelling	Visual changes
Complete loss of feeling	Rash	Difficulty breathing
Complete loss of strength	Debilitating headache	Shortness of breath
Loss of coordination	Nausea	Chest pain
Trouble balancing	Vomiting	Difficulty swallowing

Are you pregnant? (Women only) □ Yes □ No

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REVIEW OF SYSTEMS

PAST MEDICAL HISTORY

Hospitalizations/Fractures/Serious Illnesses

Date:	For what?

Surgeries:

Date:	For what?

Have you ever had any of the following (circle):

Tumors – benign/malignant Infection Concussion Cancer Broken Bones Fatigue

Eyes: recent prescription change, vision loss, eye disease

Ear, nose, throat: hearing loss, sinusitis, polyps, jaw problems, thyroid problems

Cardiovascular: chest pains, calf pain, foot/ankle/leg swelling

Respiratory: shortness of breath, asthma

Gastrointestinal: heartburn, constipation diarrhea

Urinary: incontinence, pain on urination or bowel movement

Skin: discoloration, skin cancers

Current health problems:

_____

_____

Current medications:

Name?	For?	Name?	For?

Family Medical History:

Has any member of your immediate family had any of the following disorders? Please list family member next to disorder. M=Mother F=Father B=Brother S=Sister MGM=Maternal Grandmother MGF=Maternal Grandfather PGM=Paternal Grandmother PGF=Paternal Grandfather

High Blood Pressure _____ Heart Disease _____

Cancer _____ Diabetes _____

Thyroid _____ Kidney _____

Arthritis _____ Tuberculosis _____

Stroke _____ Lung Disease _____

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Social History:

Do you drink alcohol? □ Yes □ No If yes, how many drinks per week? _____

Do you smoke? □ Yes □ No If yes, how many packs per week? _____

For how many years? _____

Do you exercise? □ Yes □ No If yes, what type? _____

How frequently? _____

Do you primarily □ sit or □ stand at work?

OFFICE POLICIES

Welcome to Washington Injury and Sports Performance Clinic. It is our goal to provide you with the best Chiropractic and rehabilitative care available in the area. This includes a clear definition of our office policies states below. Please take time to read and sign where appropriate. If you have any questions please do not hesitate to ask. We look forward to working together to help you regain and maintain your health!

On your first visit the doctor will take a history and perform a thorough examination. You should wear comfortable/athletic clothing for your appointments. For the initial visit please bring any related x-rays, MRIs, or any other diagnostic test results you may have. Please think about your condition and be able to answer the following questions:

- ◊ When did your pain begin? Was the onset sudden or gradual?
- ◊ Where is the specific site of your pain? If there is more than one area, which is most painful and most important to treat?
- ◊ What activities or movements increase your pain?
- ◊ What movements or activities are you unable to perform due to your condition?

APPOINTMENT POLICY

Your appointment time is reserved for you only. Our office does not double book appointments. 24 hour notice is required should you need to cancel an appointment. If you do not call and do not show up for your appointment you will be charged a no-show fee. If you call less than 24 hours before your appointment you will be charged a late cancellation fee. It is important that you be on time for your appointment. If you are late, we will make every effort to see you, but it may not always be possible. Arriving more than 10 minutes late for a new patient appointment will subject you to cancellation upon your arrival.

Signature: _____ Date: _____

PAYMENT POLICY

If you have a payment due at the time of your visit (i.e. a co-payment, or cash patient) payment shall be remitted at the time of your appointment. If you have a coinsurance or deductible owed you will be billed. Bills sent out for outstanding balances are due immediately. Failure to respond may result in your account being sent to collections. We accept cash, check, American Express, Master Card and Visa. A $30 reprocessing fee will be

charged to your account should any personal check fail to clear. If you are unable to afford the cost of your treatment please speak with the office manager to arrange a payment plan.

Signature: _____ Date: _____

We want your experience with our clinic to be a good one. What goals would you like to achieve through your treatment here?

_____

_____

NOTICE OF PRIVACY PRACTICES SUMMARY

When it comes to your health information, you have certain rights. You have the right to: Get a copy of your paper or electronic medical record; Correct your paper or electronic medical record; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; File a complaint if you believe your privacy rights have been violated.

We may use and share your information as we Treat you; Run our organization; Bill for your services; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests; Work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; Respond to lawsuits and legal actions.

Our responsibilities are as follows: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

All requests for information must be made in writing either mailed or faxed to the practice at the address below. Our privacy contact is Dr. Paul Glodzik, he can be reached at the contact information below or at injuryfreeperformance@gmail.com

This notice is effective as of August 14, 2014. A complete copy of the notice of privacy practice is available at the reception desk. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

By signing below you acknowledge that you have read and agree to the terms stated above.

Signature: _____ Date: _____

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