# Welcome to Dickerson Chiropractic

906 N. Llano St., Fredericksburg, TX 78624

Patient Case History

Name:_____ Sex: Male Female Date:_____

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

H. Phone:_____ W. Phone:_____ DOB:_____ Age:_____

Cell phone: _____ E mail Address:_____

Referred by:_____ SS#:_____ DL#:_____

Height:_____ Weight:_____ Marital Status: Single Married Divorced Widowed Separated

Occupation:_____ Employer:_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

**1. Chief Complaint:**_____

Other factors contributing to the 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 compliant/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? _____

**2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____**

_____

**3. Health History: Primary Care Physican:_____Phone#:_____**

**A. Previous illnesses you've had in your life:** _____

_____

**B. Previous injury or trauma:** _____

_____

Have you ever broken any bones? Which?_____

**C. Allergies:**_____

**D. Medications and reason for taking:** _____

_____

_____

**E. Surgeries:**

Date and Type of surgery:_____

_____

**F. Females ONLY:** Pregnancies, Date of Delivery and Outcome:_____

_____

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

4**. Family Health History:**

Associated health problems of relatives: _____

_____

Deaths (cause of parents or siblings death and Age at death):_____

_____

**5. Social and Occupational History:**

**A. Level of Education:** High School some college college graduate post graduate studies

**B. Job Description:** _____

**C. Work Schedule:** _____

**D. Recreational activities:** _____

**E. Lifestyle** (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

_____

Contact in case of Emergency:_____Phone#:_____

Who is responsible for the bill? _____Self _____Spouse _____Insurance ___Other, Explain?_____

**Insurance Coverage**

Primary Insurance Carrier:_____ID#_____

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and from policy to policy. Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of the bill. We do accept certain insurance assignments but all insurance arrangements must be approved in advance with the business office. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorized my physician to make credit inquiries and submit claims for benefits and collect monies for services rendered. We do charge a fee for missed appointments without 24 hour notice.

**Comprehensive Medical History**

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature:_____Date:_____

Doctor's Signature:_____Date:_____

## Please check all conditions you currently have or previously had:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **General Questions** | O | Heart attacks | | **Endocrine** | O | Vomiting |
| O | weight loss | O | Heart failure | O | Diabetes | O | Ulcers |
| O | weight gain | O | High blood pressure | O | Sickle Cell | O | Heartburn |
| O | change in sleep patterns | O | Low blood pressure | O | Abnormal body hair | O | Hepatitis |
| O | change in activity capacity | O | Irregular heart rate | O | Changes in skin texture | O | Indigestion |
| | | O | Purple fingers or lips | O | Cold intolerance | O | Abdominal pain |
| | **Neurological and psychiatric** | O | Leg pain that resolves w/ rest | O | Heat Intolerance | O | Anal fissures |
| O | Anxiety | O | Heart palpitations | O | "borderline" diabetes | O | Black tarry stools |
| O | Headaches | O | Varicose veins | O | Increased loss of hair | O | Vomiting blood |
| O | Depression | | | O | Rheumatism | O | Constipation |
| O | Meningitis | | **Respiratory** | O | Thyroid disease | O | Nausea |
| O | Paralysis | O | Pleurisy | | | O | Problems swallowing |
| O | Seizure | O | Wheezing | | **Male & Female** | O | Hiatal hernia |
| O | Stroke | O | Asthma | O | Painful intercourse | O | Intestinal obstruction |
| O | Tingling | O | Breathlessness lying flat | O | Loss of sexual interest | O | Liver disease |
| O | Tremors | O | Prolonged cough | O | Unprotected sex | O | Hemorrhoids |
| O | Memory loss | O | Coughing up blood | O | Groin itching | O | Red blood after BM |
| O | Fainting spells, dizziness | O | Emphysema | O | STD | | |
| O | Head Injuries | O | Shortness of breath | | | | **Females Only** |
| O | Blackouts or near blackouts | O | Tuberculosis | | **Males Only** | O | D + C |
| O | Change in sensation | O | Pneumonia | O | Hernia | O | Hot flashes |
| | anywhere on your body | O | Chronic bronchitis | O | Sterility | O | Hernia |
| O | Localized weakness or | | | O | Bloody ejaculation | O | Fibroids |
| | numbness | | **Skin** | O | Inability to complete | O | Abnormal bleeding |
| | | O | Abscess | O | intercourse | O | between cycles |
| | **Ears, Eyes, Nose & Throat** | O | Acne | O | Lump on testicle | O | Abnormal pap smear |
| O | Hay fever | O | Boils | O | Penile discharge | O | Bleeding after intercourse |
| O | Glaucoma | O | Hives | O | Premature ejaculation | O | Complications with |
| O | Polyps | O | Dandruff | O | Problems maintaining | | pregnancy |
| O | Allergy | O | Oily skin | | an erection | O | PMS |
| O | Cataracts | O | Rashes | O | Prostate disease | O | Endometriosis |
| O | Goiter | O | Dry skin | O | Sores on penis or warts | O | Heavy bleeding during |
| O | Hoarseness | O | Psoriasis | O | Testicular pain | | cycles |
| O | Double vision | O | Lumps | O | Testicular swelling | O | Discharge from breasts |
| O | Gum problems | O | Jaundice | | | O | Ovarian cysts |
| O | Eye problems | O | Athlete's foot | | **Musculoskeletal** | O | Pelvic inflammatory dis. |
| O | Ear infections | O | Excessive body odor | O | Anemia | O | Postmenopausal |
| O | Glasses/contacts | O | Excessive sweating | O | Back pain | | symptoms |
| O | Hearing loss | O | Fungal infections | O | Arthritis | O | Vaginal discharge |
| O | Ear discharg/pain | O | Nail problems | O | Bursitis | O | Vaginal dryness |
| O | Frequent nosebleeds | O | Moles--irregular | O | Joint pain | O | Vaginal warts |
| O | Ringing in your ears | | | O | Tendonitis | | |
| O | Sinus infections | | **Kidneys & Urinary Tract** | O | Gout | | Provider Notes: |
| O | Swollen glands | O | Blood in urine | O | Neck pain | | |
| | | O | Brown urine | O | Abnormal blood counts | | |
| | **Cardiovascular** | O | Dribbling after urination | O | Blood clots in legs/lungs | | |
| O | Angina | O | Painful urination | O | Bone Marrow biopsy | | |
| O | Chest pain | O | Excessive thirst | O | Easy bleeding | | |
| O | Murmurs | O | Incontinence | O | Easy bruising | | |
| O | Leg Cramps | O | Urinating frequently (day) | O | Joint swelling | | |
| O | Ankle swelling | O | Urinating frequently (night) | O | Morning stiffness | | |
| O | Awakening at night short of | O | Urine hesitancy | O | Muscle aches | | |
| | breath & getting out of bed | O | Weak flow | | | | |
| O | Cardiac catheterization | O | Frequent bladder infections | | **Gastrointestinal** | | |
| O | Cold hands or feet | O | Kidney disease | O | Diarrhea | | |
| O | Congenital heart defect | O | Kidney stone | O | Gallstones | | |
| O | Dizziness when standing | | | O | Reflux | | |

# DICKERSON CHIROPRACTIC
## TREATMENT AUTHORIZATION

I, _____, certify that the complaints listed below are true as related by me. I wish to be treated for these complaints and any additional complaints or problems, which may arise during the course of my treatment in this office today.

| COMPLAINTS/ | ACTIVITIES IMPAIRED DUE TO CONDITION |
|---|---|
| 1. | / |
| 2. | / |
| 3. | / |
| 4. | / |
| 5. | / |
| 6. | / |

**VISUAL PAIN INTENSITY SCALE**

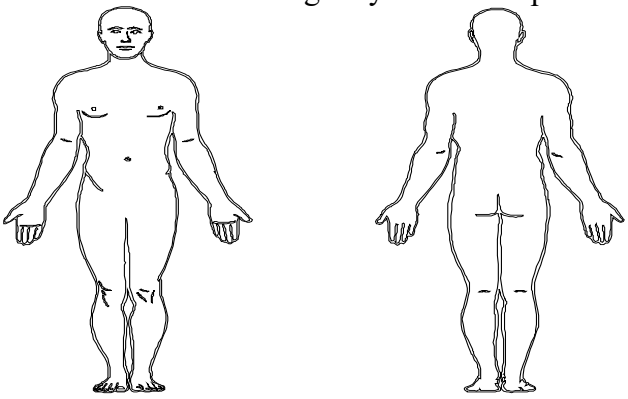
What is your pain ***RIGHT NOW***?
*No pain* 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

What is your ***TYPICAL or AVERAGE*** pain?
*No pain* 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

What is your pain level ***AT ITS BEST*** (How close to "0" does your pain get at its best)
*No pain* 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?
*No pain* 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

Shade or mark on the figure your area of pain



Date:_____

Patient's Signature: _____
Legal Guardian Signature:_____

# DICKERSON CHIROPRACTIC

906 N. Llano St., Fredericksburg, TX 78624

## Acknowledgement for Consent to Use and Disclosure of Protected Health Information

**Use and Disclosure of your Protected Health Information**
Your Protected Health Information will be used by **Dickerson Chiropractic** or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care operations of this office.

**Notice of Privacy Practices**
You should review the Notice of Privacy Practices for a more complete description of how your Personal Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created by this office. You may review the Notice of Privacy Practices prior to signing this consent. You may request a copy of the Notice at the Front Desk .

**Requesting a Restriction on the Use or Disclosure of Your Information**
You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**
This office reserves the right to modify the privacy practiced outlined in this Notice.

**Signature**
I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

_____
Name of Patient (print)

_____
Signature of Patient Date

_____
Signature of Patient Representative Date

_____
Relationship of Patient Representative to Patient

_____
Office Representative Date

_____
Others we may release your PHI to

# DICKERSON CHIROPRACTIC

906 N. Llano St., Fredericksburg, TX 78624

## INFORMED CONSENT TO CHIROPRACTIC SPINAL MANIPULATION AND SUPPORTIVE CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-ray, on me (or the patient named below, for whom I am legally responsible) by Dr. Rex Dickerson and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working for or associated with or serving as backup for Dr. Dickerson, including those working 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 and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I understand and comprehend all such risks and complications. I, by my signature below, consent to and agree to those treatments deemed by my doctor to be in my best interest.

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.

_____

Print Patient's Name

_____

Signature of Patient

_____

Date signed

_____

Doctor treating this patient and witness signature

To be completed by patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

_____

Print Patient's Name

_____

Print Name of Representative

_____

Relationship of Representative

_____

Date signed

# Dickerson Chiropractic

Dr. Dickerson performs services based on each patient's needs each visit. He takes great care in providing the best care for each patient on each and every visit. Often times there are services that will make the patient visit more effective and beneficial but are not covered when performed with an adjustment or on the same day as an adjustment. This letter is to inform you as the patient that Dr. Dickerson will perform the services that are in the best interest of the patient and their care. Dr. Dickerson is not a provider for most insurance companies however; we strive to help our patients utilize any benefits that may be available. By signing this form, you acknowledge that you may receive services that will not be covered by your insurance. Stretching and any massage or muscle work will not be covered on the same day you receive an adjustment.

I,_____ agree to receive services that may not be covered by my insurance, but are in my best interest and care.

Signed_____Date_____

I,_____ do not want to receive services that may not be covered by my insurance even though they may be in my best interest and care.

Signed_____Date_____

Staff signature:_____