

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Male Female SSN _____

Employer _____ Occupation _____

Marital Status _____ Name of spouse _____ # of Children _____

Do you have Health and Insurance? _____ If yes, with what company? _____

Who is responsible for this account? _____

Email Address _____ Referred By _____

Emergency Contact _____ Phone _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT

O = OCCASIONAL
F = FREQUENT
C = CONSTANT

O F C

GASTRO-INTESTINAL

O F C

CARDIO-VASCULAR

O F C

GENERAL

- Allergy
- Chills
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness/depression
- Numbness
- Sweats
- Tremors

MUSCLE AND JOINT

- Arthritis
- Bursitis
- Hernia
- Low back pain
- Lumbago
- Neck pain or stiffness
- Pain between shoulders
- Pain or numbness in:
- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tailbone
- Poor posture
- Sciatica
- Spinal curvature
- Swollen joints

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distension of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Crossed eyes
- Deafness
- Dental decay
- Earache
- Ear noises
- Enlarged glands
- Enlarged thyroid
- Eye pain
- Failing vision
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Nosebleeds
- Sinus infection
- Sore throat

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

SKIN

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Varicose veins

GENITO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Inability to control kidneys
- Kidney infection or stones
- Painful urination
- Prostate trouble
- Pus in urine
- Sexual dysfunction

FOR WOMEN ONLY

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge
- Yes No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Influenza | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping cough |

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

What is your major complaint? _____

Other complaints _____

Have you ever had previous chiropractic care or physical therapy? _____ If yes, date of last care _____

How long have you had this condition? _____ Have you had this or a similar condition in the past? _____

What activities aggravate you condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your: Work Sleep Daily routine Other: _____

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for your present condition _____

List surgical operations and years _____

Medications and vitamins you now take _____

Have you been in an auto accident? Past year Past five years Over five years Never

Describe _____

Have you been in a work related accident? Past year Past five years Over five years Never

Describe _____

Have you ever had any mental or emotional disorders? Yes No When? _____

PLEASE CIRCLE AS MANY ANSWERS THAT APPLY TO THE FOLLOWING QUESTIONS

1. How have you taken care of your health in the past?

- a. medications
- b. emergency room
- c. routine medical
- d. exercise
- e. nutrition/diet
- f. holistic care
- g. vitamins
- h. chiropractic
- i. other

2. How did the previous method(s) work out for you?

- a. bad results
- b. some results
- c. great results
- d. nothing changed
- e. did not get worse
- f. did not work very long
- g. still trying
- h. confused

3. How have others been affected by your health condition?

- a. no one is affected
- b. haven't noticed any problem
- c. they tell me to do something
- d. people avoid me

4. What are you afraid your health condition might be affecting?

- a. job
- b. kids
- c. future ability
- d. marriage
- e. self-esteem
- f. sleep
- g. time
- h. finances

5. Are there health conditions you are afraid this might turn into?

- a. family health problems
- b. heart disease
- c. cancer
- d. diabetes
- e. arthritis
- f. fibromyalgia
- g. depression
- h. chronic fatigue
- i. need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples: _____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples: _____

What are you most concerned with regarding your problem? _____

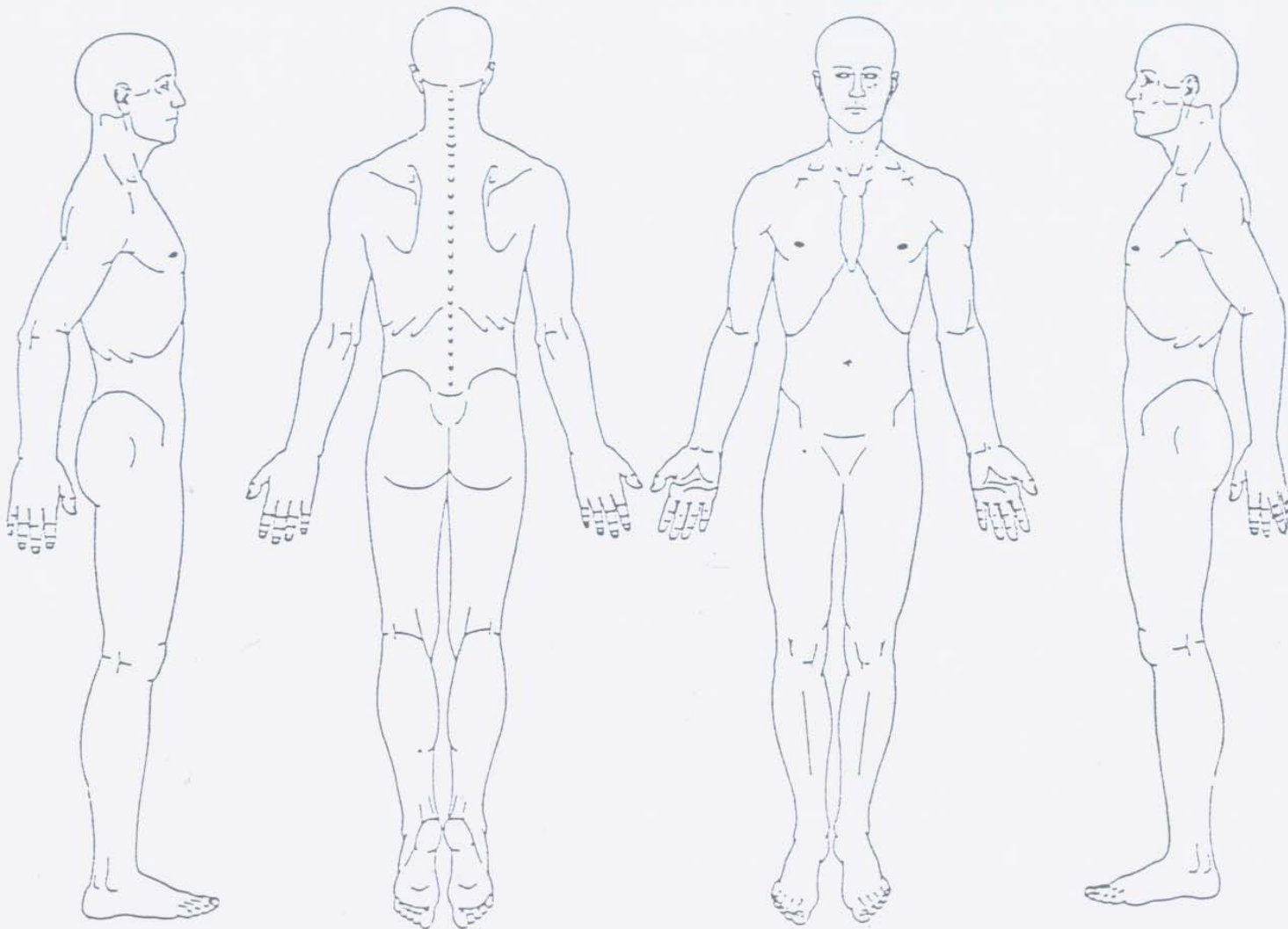
Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

What would be different/better without this problem? Please be specific _____

What do you desire most to get from working with us? _____

What is that worth to you? _____

How would you rate your motivation to improving your condition? _____



Name _____
Date _____
DOB _____
SSN _____

1. Please shade in all areas of complaints/problems even if you feel it is unrelated to why you are here.

2. Next to the shaded area describe the problem: burning, aching, weakness, stiffness, tingling, numbness, soreness, sharp pain, etc.

TEAM HEALTH CARE CLINIC, P.C. 12217 CHAMPLIN DRIVE CHAMPLIN, MN 55316
(763) 323-1492 TAX ID NUMBER 41-1909135

BILLING POLICY

It is important that you understand that, as your health care provider, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. Please try to remember that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. Our office cannot be responsible for monitoring each contract exclusion or limitation.
3. There are some services done in this clinic that are not covered by most insurance companies, including BCBS and Medicare. They include: VAX-D, EDS, NAET, nutrition consultations, massage, many blood tests (including the vitamin D test), foot orthotics, acupuncture, FLT, laser treatments and wellness or maintenance chiropractic care.
4. We will be happy to contact your insurance company to determine your benefits, however, any information our office gives you is an estimate based on the information available to us. Any changes in your insurance coverage should be reported to Team Health Care Clinic, P.C. immediately.
5. Accounts that have patient balances due and there's no payment made for thirty days may be charged a \$20 rebilling fee every month. It is our policy that any balances over 60 days may be turned over to a collection agency. You will also be responsible for any fees involved in the collection process. These overdue accounts would be reported to the credit bureau.
6. Due to the limited scheduling and high demand for Dr. Leach's services and EDS testing there is a \$25 fee for all missed appointments. There will not be a fee if the cancellation is at least 24 hours in advance of the scheduled appointment.

I have read and agree to the above _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

1. Disclosures of your protected health information without authorization are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. We will also send daily notes/records with medical billing, as necessary, to insure proper processing. We will disclose information for the purposes of treatment and practice operations as well. You may request restrictions on disclosures.
2. YOU AUTHORIZE TEAM HEALTH CARE CLINIC TO DISCUSS YOUR TREATMENT AND ACCOUNT WITH YOUR SPOUSE OR ANOTHER FAMILY MEMBER.
3. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.
4. You may inspect and receive copies of your records within seven (7) days of a request. There may be a reasonable cost-based fee for photocopying, postage and preparation.
5. You may request changes to your records. Our practice has the right to accept or deny the request.
6. We maintain a history of protected health information disclosures that is accessible to you.
7. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.
8. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations with the Office Manager.

I have read and agree to the above _____

TEAM HEALTH CARE CLINIC WILL BILL YOUR INSURANCE

I authorize payment of medical benefits to the physicians at Team Health Care Clinic, P.C. for services supplied to me. I also authorize the release of any medical information, or information necessary to process my claims.

Print Name

Signature

Date

BILL YOUR OWN INSURANCE & PAY CHARGES IN FULL

I choose not to sign the authorization and agree to pay for my services in full at the time of each visit. I also authorize the release of any medical information, or information necessary to process my claims.

Print Name

Signature

Date