Case History

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
H. Phone (_____)_____ W. Phone _____ Date of Birth _____ (Age _____)
Email _____ Social Security # _____
Referred by _____
Occupation _____ Employer _____
Marital Status S M D W Spouses Name _____
Spouses Occupation _____ Number of Children and Ages _____
Have you ever received Chiropractic Care? □ Yes □ No

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	No		Patient Comments if answer is Yes	Chiropractor's comments
		1. When you were born:		
□	□	Was the delivery long?		
□	□	Was the delivery difficult?		
□	□	Were forceps used?		
□	□	Were you breech?		
□	□	Was it a home birth?		
□	□	Was it a hospital birth?		
□	□	Was your mother given drugs?		
□	□	Was labor induced?		
		2. Growth and Development		
□	□	Were you taught how to care for your spine?		
□	□	Did you fall out of bed?		
□	□	Were you a headbanger or rocker?		
□	□	Were you breast fed?		
□	□	Childhood Sickness?		
□	□	Accidents?		
□	□	Surgery?		
□	□	Drugs?		
□	□	Did you fall while learning to walk?		
□	□	Were you picked on by siblings?		
□	□	Child Abuse		
□	□	Spanking (how?)		
□	□	Pulling ear/chin		
□	□	Other		
□	□	Chair pulled out when sat down?		
□	□	Did you fall down stairs		

Yes	No	3. Current Health Habits		
□	□	Did/do you smoke?	_____	_____
□	□	Did/do you drink any alcohol?	_____	_____
□	□	Diet (Do you eat health foods?)	_____	_____
□	□	Have you been in accidents?	_____	_____
□	□	Have you had surgery and organs Removed/replaced?	_____	_____
□	□	Drugs? (Prescriptive or non-prescriptive)	_____	_____
□	□	Teeth problems?	_____	_____
□	□	Eye problems?	_____	_____
□	□	Hearing problems?	_____	_____
□	□	Exercise regularly?	_____	_____
□	□	Sleeping habits (nightmares?)	_____	_____
□	□	Did/do you have occupational stress?	_____	_____
□	□	Physical stress?	_____	_____
□	□	Mental stress?	_____	_____
□	□	Hobbies/Sports injuries?	_____	_____
□	□	Sleeping posture □ side □ stomach □ back	_____	_____

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Major Complaint _____

Pain or Problem started on _____

Pains are: □ Sharp □ Dull □ Constant □ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work?_____ Sleep?_____ Routine?_____ Other?_____

Is condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

□ Headaches	□ Pins & Needles in Legs	□ Fainting
□ Neck Pain	□ Pins & Needles in Arms	□ Loss of Smell
□ Sleeping Problems	□ Numbness in Fingers	□ Loss of Taste
□ Back Pain	□ Numbness in Toes	□ Diarrhea
□ Nervousness	□ Shortness of Breath	□ Feet Cold
□ Tension	□ Fatigue	□ Hands Cold
□ Irritability	□ Depression	□ Stomach Upset
□ Chest Pains	□ Lights Bother Eyes	□ Constipation
□ Dizziness	□ Loss of Memory	□ Cold Sweats
□ Face Flushed	□ Ears Ring	□ Loss of Balance
□ Neck Stiff	□ Fever	□ Buzzing in Ears

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	□	□	□	□	□
Mother's side	□	□	□	□	□

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins the **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

afc Wellness
Anderson Family Chiropractic and Naturopathic Care
751 Michigan Ave, PO Box 254, Waterville OH 43566 • 419-878-8312

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Anderson Family Chiropractic LLC "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Anderson Family Chiropractic LLC Notice of Privacy Practices prior to signing this document. Anderson Family Chiropractic LLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices 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 Anderson Family Chiropractic LLC. The Notice of Privacy Practices for Anderson Family Chiropractic LLC is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Anderson Family Chiropractic LLC duties with respect to my protected health information.

Anderson Family Chiropractic LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices 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.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

The following individual(s) may have access to any and all information involving the care I receive from Anderson Family Chiropractic:

Name: _____

Relation: _____ Phone: _____

Name: _____

Relation: _____ Phone: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination, we encounter a non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I _____ have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Signature _____ Date _____

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PAYMENT POLICY

Payment is due at the time services are rendered. After 60 days of non-payment, an 8% interest fee will be added to your account to be compounded monthly. There is a $25.00 returned check fee, which is to be paid no more than three (3) business days after notification from AFC.

A four (4) hour notice is required for all canceled appointments or you may be subject to a fee. Missed appointments will result in a $20.00 rescheduling fee.

INSURANCE ASSIGNMENT PROGRAM

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. If you have any form of an insurance reimbursement account, such as, but not limited to, a Health Savings Account, it is your responsibility to retrieve your money from that account. We will still expect payment when services are rendered. You are also entitled to one free copy of medical records.
2. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during your corrective care period. Direct assignment will be discontinued when you have finished corrective care and supportive health care program is recommended. We will notify you of the change.
3. All deductible amounts must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments may also be made.
4. The insurance carriers are billed on specific 7-10 day cycles. It is your responsibility to supply this office with necessary forms to complete billing if needed. Social Security numbers are required by this facility for billing and financial services and by refusing to provide this information you acknowledge that you may be refused service.
5. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action. Provided, however, that if your delinquent account is turned over to a 3rd party collection agency, then you agree to pay all reasonable collection costs including reasonable attorney fees and court costs.
6. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue care.
7. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own. The insurance company has 30 days from billing date to make this decision. Patient payment is expected on any fees over 30 days old.

I have read the above provisions and wish to participate in the cash/insurance assignment program. I hereby agree to abide by the provisions as specified above.

Patient's Signature _____ Date _____

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Insurance Information

Patient: _____
Policy Holder: _____
Social Security #: _____
Date of Birth: _____
Employer: _____
Claim Group: _____
ID#: _____

I hereby instruct and direct _____ Insurance Company to pay

Anderson Family Chiropractic, LLC PO Box 254 Waterville, OH 43566

For any and all services performed in and/or provided by their office.

Patient authorizes the Doctor to deposit checks received on Patient's account from the above insurance provider when made out to the Patient.

In case of emergency, please contact:

1st Contact _____
Address _____
_____
Phone _____

2nd Contact _____
Address _____
_____
Phone _____

_____ _____
Patient Signature Date