Feldkamp Chiropractic Clinic, Inc.

CASE HISTORY

Patient # _____

Patient Information Date: _____

Name:_____
Address:_____
City: _____ State: _____ Zip: _____
Home Telephone: (_____)_____ Cell Phone: (_____)_____ Work Telephone: (_____)_____
Social Security #: _____ Birthdate: _____ Sex: ☐ M ☐ F
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Minor
E-mail: _____
Employer/School: _____ Occupation: _____ Years Employed: _____
Spouse's or Parent's name: _____ Spouse/Parents Occupation: _____
Person to contact in case of emergency: _____ Phone #: _____

Do you have Insurance that you want our office to send claims?
Primary Insurance
Insurance name: _____ Ins Policy holder name: _____
Your relationship to policy holder: ☐ self ☐ spouse ☐ child ☐ other _____
Secondary Insurance
Insurance name: _____ Ins Policy holder name: _____
Your relationship to policy holder: ☐ self ☐ spouse ☐ child ☐ other _____

Symptoms

Reason for visit/What is your major Complaint? _____
Other Complaints: _____
How did your symptoms begin and how long have you had your symptoms? _____
_____
_____
Are your symptoms changing? ☐ Getting better ☐ Getting worse ☐ Staying the same
Have you had similar symptoms in the past? ☐ Yes ☐ No When? _____
Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine ☐ recreation ☐ other: _____
Please Rate your Pain on the scale below.

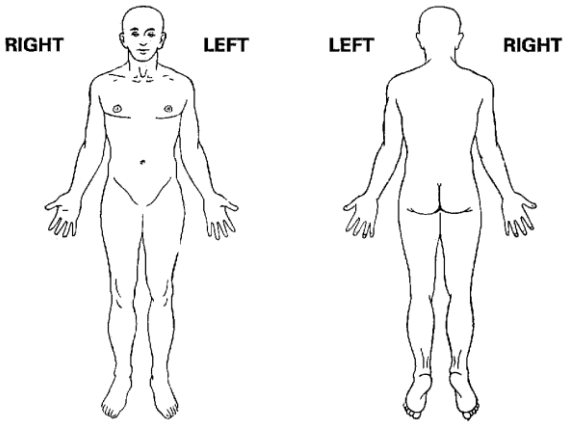
No Pain ◄——————————————► Worse Pain
0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms worse? _____
_____
What makes your symptoms better? _____
_____
Is there movement/radiation of your symptoms? ☐ Yes ☐ No
If yes from where to where? _____

Is there a particular time when your symptoms are ☐ better or ☐ worse? ☐ Yes ☐ No
When:_____
How often do you get your symptoms? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (0-25%)

Where are you symptoms located?
(Please Mark Drawing with symbols below)

- ☐ Sharp ///
- ☐ Dull ===
- ☐ Achy +++
- ☐ Throbbing ***
- ☐ Numbness NNN
- ☐ Shooting SSS
- ☐ Burning ^^^
- ☐ Throbbing ???
- ☐ Stiffness ###
- ☐ Other _____



How tall are you? _____ Feet _____ inches

How much do you weigh? _____ Lbs

Is your condition a result of an accident? ☐ Yes ☐ No
Type of accident? ☐ Auto ☐ Work ☐ Home ☐ Other please explain _____

Prior Interventions: What have you done to relieve this problem?

- ☐ Over the counter medication: (Please List) _____
- ☐ Prescription medication: (Please List) _____
- ☐ Acupuncture ☐ Massage ☐ Ice ☐ Heat
- ☐ Physical Therapy: Type of treatment and results: _____
- ☐ Went to Family Doctor: Type of treatment and results: _____
- ☐ Went to a Specialist: Type of treatment and results: _____
- ☐ Other: _____

Have you had any special tests done? ☐ Yes ☐ No If YES when were they done and what were the results?

- ☐ X-rays: Results_____
- ☐ MRI/CT: Results_____
- ☐ Other: Results:_____

Describe any serious Accidents, Illness, or injuries you have had? When they occurred and if you were Hospitalized?
_____
_____

Please List all the Medications (Prescription and Non Prescription) you are taking.
_____
_____
_____

Please List all the surgeries you have had.
_____
_____
_____

Family History

Does any of your immediate family (Mother, Father Brothers or Sisters) have or has had any of the following diseases or other serious illness?
Please check all that apply

☐ Heart disease ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Other _____

Social History

Alcohol Use ☐ Daily ☐ Weekly ☐ Never How much? _____
Tobacco Use ☐ Daily ☐ Weekly ☐ Never How much? _____
Excessive Exposure to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air bourn particle ☐ Other: _____

Are you Pregnant? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

Yes	No	
☐	☐	History of major or minor trauma? Motor vehicle accident, fall, strenuous lifting
☐	☐	Age 50 or more
☐	☐	Past or present history of cancer
☐	☐	Fever over 100 degrees, sensation of being cold, wake up sweating, temperature changes at night?
☐	☐	Unexplained weight loss of over 10 lbs. in 3 months, not directly related to a change in diet or exercise.
☐	☐	Recent bacterial infection such as a urinary tract infection
☐	☐	Immunosuppression resulting from a transplant, intravenous drug abuse or prolonged steroid use
☐	☐	Pain that is not relieved with rest or awakens the patient at night, which is unrelated to movement or positioning
☐	☐	Saddle anesthesia (numbness in the groin region)
☐	☐	Acute onset urinary retention, changes in frequency of urination, incontinence, painful urination, or blood in urine
☐	☐	Progressive or severe muscle weakness in the legs (legs give out)

Review of Systems

Review of Systems: Please mark "X" for YES or leave a blank for NO:

CONSTITUTIONAL
☐ Fever
☐ Weight gain/loss
☐ Fatigue
☐ Night Sweats
☐ Weakness
☐ Other_____

PSYCHOLOGICAL
☐ Depression
☐ Anxiety
☐ Other_____

SKIN
☐ Rash
☐ Lumps
☐ Itching
☐ Easy bruising
Other_____

EYES
☐ Double vision
☐ Blurred vision
☐ Cataracts
☐ Other_____

EARS, NOSE, MOUTH, THROAT
☐ Hearing loss
☐ Ringing in the ears
☐ Vertigo/Dizziness
☐ Sinus problems
☐ Sore throat
☐ Swollen glands
☐ Other_____

CARDIOVASCULAR
☐ Chest pain
☐ Racing heart
☐ Leg swelling
☐ High blood pressure
☐ Shortness of breath
☐ Rheumatic fever
☐ Other_____

RESPIRATORY
☐ Cough
☐ Coughing up blood
☐ Wheezing
☐ Shortness of breath
☐ Bronchitis
☐ Other_____

GASTRONTESTINAL
☐ Trouble swallowing
☐ Heartburn
☐ Vomiting/ Diarrhea
☐ Abdominal pain
☐ Blood in stool
☐ Constipation
☐ Nausea
☐ Difficulty controlling bowels
☐ Other_____

GENTITOURINARY
☐ Pain/Burn on urination
☐ Urgency/ Hesitancy
☐ Blood in urine
☐ Incontinence
☐ Irregular menstruation
☐ Pregnant
☐ Venereal Disease
☐ Painful Menstruation
☐ Other_____

MUSCULOSKELETAL
☐ Arthritis
☐ Joint swelling
☐ Weakness
☐ Cramps
☐ Back pain
☐ Neck pain
☐ Other_____

NEUROLOGICAL
☐ Fainting
☐ Blackouts
☐ Headache
☐ Seizures
☐ Paralysis
☐ Weakness
☐ Numbness
☐ Memory loss
☐ Tingling
☐ Other_____

ENDOCRINE
☐ Heat or cold intolerance
☐ Sweating
☐ Thirst
☐ Hunger
☐ Diabetes
☐ Thyroid trouble
☐ Other_____

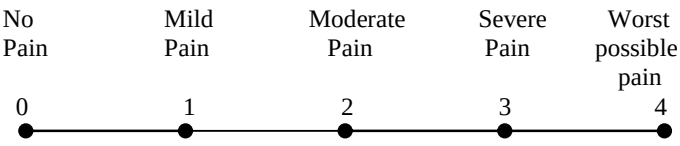
HEMATOLOGY/LYMPHATICS
☐ Bruising
☐ Bleeding
☐ Other_____

Feldkamp Chiropractic Clinic
Functional Rating Index

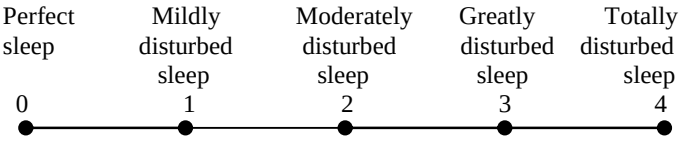
In order to properly assess your condition, we must understand how much your symptoms affect your ability to manage everyday activities. For each item below, **please circle the number, which most closely describes your condition right now.**

Patient Name: _____ Date: _____

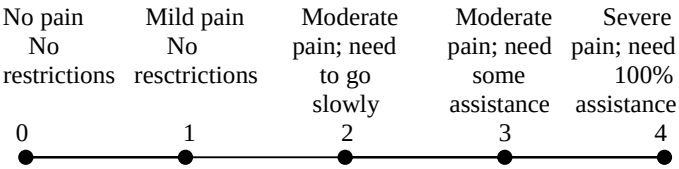
Pain Intensity



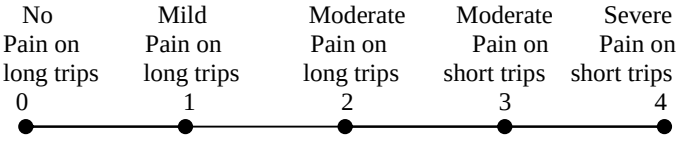
Sleeping



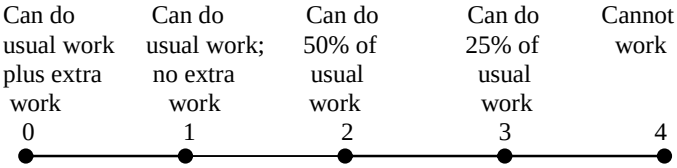
Personal Care (washing, dressing, etc.)



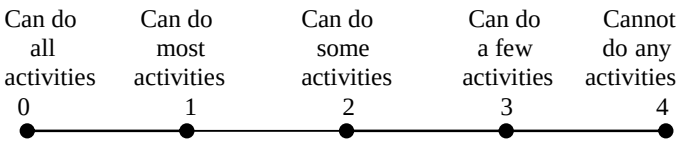
Travel (driving, etc.)



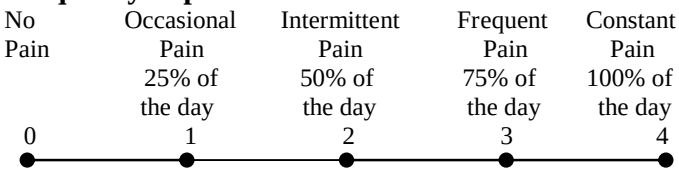
Work



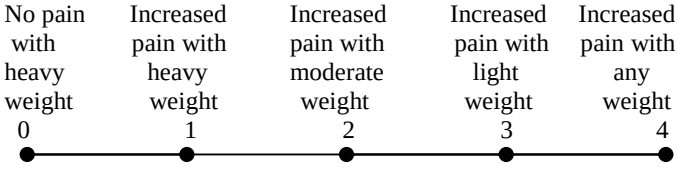
Recreation



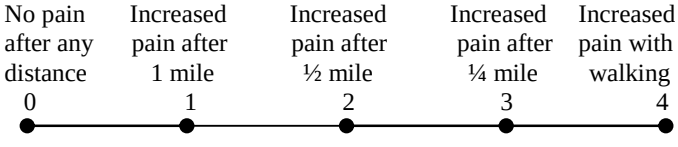
Frequency of pain



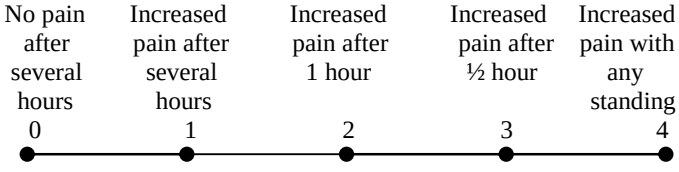
Lifting



Walking



Standing



Acknowledgements

To set clear expectations, improve communications and to help you get the best results in the shortest amount of time, please read each statement, complete if applicable and sign at the bottom.

- I instruct the Doctor to deliver the care that in his professional judgment can best help me in the restoration of my health.

- I have been given a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf.

- I grant permission to be called, emailed, texted or by other electronic media to confirm or reschedule an appointment. I also grant permission to be sent occasional cards, letters, emails, texts, other electronic media, newsletters or health information to me as an extension of my care in this office. I may opt out at any time by contacting the office or by checking here. ☐

- (Female Only) I realize that the Doctor may refer me for an x-ray evaluation and that x-rays may be hazardous to an unborn child. I certify that to the best of my knowledge I am not pregnant. If I am referred for an x-ray in the future, I will advise the Doctor and technologist if I may be pregnant.

- I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

- I hereby consent and authorize Dr. Peter Feldkamp/ Dr Patrick Feldkamp and/or whomever he may designate as assistants to administer treatment to _____ (name of minor) my son/daughter/guardian.

- To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

- I certify that I and/or my dependents have insurance coverage with _____ (name of insurance company) and assign payment directly to Feldkamp Chiropractic Clinic, Inc./Dr. Peter Feldkamp/Dr Patrick Feldkamp, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Feldkamp Chiropractic Clinic, Inc./Dr. Peter Feldkamp/ Dr Patrick Feldkamp may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of patient, parent, guardian or personal representative Date

Feldkamp Chiropractic Clinic

Informed consent for chiropractic treatment

Please read this consent form, discuss it with your clinician if you would like to, and then sign where indicated at the bottom. Clinicians who use spinal manual therapy techniques, such as for example joint adjustments or manipulation or mobilization are required to inform patients that there are or may be some risks associated with such treatment. In particular:

1. While rare, some patients have experience muscle and ligaments sprains or strains, or rib fractures following spinal manual therapy.

2. The there have been reported cases of injury to the vertebral artery following neck adjustments, manipulation and/or mobilization. Such vertebral artery injuries may on rare occasion cause stroke, which may result in serious neurological injury and or physical impairment. This form of complication is an extremely rare event, occurring about one time per one million treatments.

3. There have been reported cases of disc injuries following spinal manual therapy, although no scientific study has ever demonstrated that such injuries are caused, or may be caused, by adjustment or manipulative techniques and such cases are also very rare.

Treatments provided at this clinic, including spinal adjustments, manipulation and or mobilizations, have been the subject of much research conducted over many years and have been demonstrated to be appropriate and effective treatments for many common forms of spinal pain, pain in the shoulders arms legs, headaches and other similar symptoms. Treatment provided at this clinic may also contribute to your overall well-being. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, or other treatments and procedures frequently given as alternative treatments for the same form of musculoskeletal pain and other associated syndromes.

Your clinician will evaluate your individual case, provide an explanation of care and a suggested treatment plan, or alternatively a referral for consultation and/or further evaluation if deemed necessary.

Acknowledgments: I acknowledge I have discussed, or have been given the opportunity to discuss, with my clinician the nature of chiropractic treatment in general and my treatment in particular as well as the contents of this consent.

Consent: I consent to the chiropractic treatment(s) offered or recommended to me by my clinician, including joint adjustment or manipulation or mobilization of the joints of my spine (neck and back), pelvis and extremities (shoulder, hip and upper and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Dated this _____ day of _____, 20___

_____	_____
Patient signature (Legal guardian)	Signature of Guardian when applicable
_____	_____
Please print name of the patient	Please print name of Guardian
_____	_____
Please print name of witness/translator	Signature of witness/translator

FELDKAMP CHIROPRACTIC CLINIC

Peter D. Feldkamp, D.C.
Patrick D. Feldkamp, D.C.
4227 Hoover Road Grove City, Ohio 43123
Telephone (614) 875-3338
Fax (614) 875-3034
Website: www.feldkampchiro.com

INFORMATION FOR NEW PATIENTS

OFFICE HOURS	Monday, Wednesday and Friday 8:00-12:00, 2:3000-6:00 Tuesday 2:30-4:30 Saturday 8:30-9:30; by appointment
Appointments	Appointments are set to maximize your health. We ask your cooperation in keeping to your appointments as scheduled.
Dress	For therapy purposes, women are requested to wear blouses and pants, or skirts, rather than dresses.
Insurance and Payments	Payment is expected at the time of service. Chiropractic care is covered by most insurance companies. Our office will assist you in filing your insurance forms. Patients are responsible for their insurance deductible (the amount the patient pays first before the insurance company pays), co-payments (the percentage which the insurance company does not cover), and any other charges which the insurance company does not cover. Insurance coverage is an agreement between the insurance company and the patient, not the insurance company and the doctor. We will assist you in filing your claim but the patient is ultimately responsible for their bill. This office participates in the Medicare program and does accept assignment. There are some restrictions imposed by Medicare. If you have any questions, please feel free to ask the doctor or staff. Payment arrangements are available. Please inquire at the front desk.
Referral of Friends & Family	Our office will gladly accept the referral of your friends and family.