CASE HISTORY

Name ______________________ Age __________ Date ______________________

Address ______________________ City/Zip ______________________

Home Ph ______________________ Work ______________________ Cell ______________________

DOB ______________ SSN: ______________________

Employer ______________________ Work Status: Full Time Part Time Not Employed Retired

Marital Status: S M D W # of children __________ Student: ( ) Yes ( ) No If YES, Full Time Part Time

Referring Doctor ______________________ Who Referred You To This Office ______________________

Have You Retained an Attorney ( ) Yes ( ) No Name and Address ______________________

Insurance Company ______________________ Policy Holder's Name______________________

DOB of the primary card insured ______________________ SSN of primary insured ______________________

Insurance is in the Name of: Self Spouse Parent Other Relationship to Insured: Self Spouse Other

---

Chief Complaint 1. ______________________ Duration-(How Long) ______________ Previous Episodes ________
List Current 2. ______________________ Duration-(How Long) ______________ Previous Episodes ________
Problems 3. ______________________ Duration-(How Long) ______________ Previous Episodes ________

Are your present problems due to an injury? ( ) No ( ) Yes ( ) On the Job ( ) Auto Accident ( ) Personal Injury ( ) Other
Date of Injury ______________ Off Work Due to this Injury? ( ) No ( ) Yes Dates ______________________
Has the accident been reported? ( ) No ( ) Yes ( ) To Employer ( ) Auto Carrier ( ) Other ______________
Have you retained an attorney? ( ) No ( ) Yes Name and Address ______________________

Please Mark the intensity of your pain today

1 – NO PAIN
10 – MOST INTENSE PAIN EVER FELT

Example ______ Neck ______________________
1 2 3 4 5 6 7 8 9 10

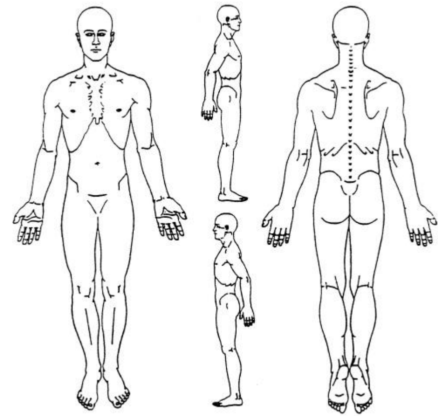
1. ______________________
1 2 3 4 5 6 7 8 9 10

2. ______________________
1 2 3 4 5 6 7 8 9 10

3. ______________________
1 2 3 4 5 6 7 8 9 10

Please mark area & type of pain on the drawings using the codes listed below

N – Numbness P – Pain T – Tingling
A – Ache S – Soreness ST - Stiffness



HABITS

- [ ] Smoking Packs/Day ________
- [ ] Drinking Alcohol Per Day ____
- [ ] Coffee Cups Per Day ______

EXERCISE

- [ ] None
- [ ] Moderate
- [ ] Daily

Type ______________

FAMILY HISTORY

	Diabetes	Heart	Stroke	Cancer	Back
Mother					
Father					
Brother					
Sister					

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

☐	Appendicitis	☐	Anemia	☐	Heart Disease	☐	Arthritis
☐	Pneumonia	☐	Measles	☐	Goiter	☐	Epilepsy
☐	Rheumatic Fever	☐	Mumps	☐	Influenza	☐	Mental Disorder
☐	Polio	☐	Chicken Pox	☐	Pleurisy	☐	Lumbago
☐	Tuberculosis	☐	Diabetes	☐	Alcoholism	☐	Eczema
☐	Whooping Cough	☐	Cancer	☐	Venereal Infection	☐	HIV Positive

Please check if you have ever had any of the associated symptoms:

GENERAL SYMPTOMS
- ☐ Allergies
- ☐ Bronchitis
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of Weight
- ☐ Numbness arms/legs

MUSCLES & JOINTS
- ☐ Backache
- ☐ Foot Trouble
- ☐ Hernia
- ☐ Pain Between Shoulders
- ☐ Painful Tailbone
- ☐ Stiff Neck
- ☐ Swollen Joints
- ☐ Tremors/Twitching
- ☐ Weakness

GASTRO-INTESTINAL
- ☐ Colon Trouble
- ☐ Excessive Hunger
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Vomiting Blood

CARDIO-VASCULAR
- ☐ High Blood Pressure
- ☐ Pain over Heart
- ☐ Poor Circulation
- ☐ Previous Heart Trouble
- ☐ Rapid Heart
- ☐ Strokes
- ☐ Swelling Ankles

EYE/EAR/NOSE/THROAT
- ☐ Earaches
- ☐ Ear Noises
- ☐ Enlarged Thyroid
- ☐ Nose Bleeds
- ☐ Poor Vision

SKIN OR ALLERGIES
- ☐ Bruising Easily
- ☐ Hives or Allergy
- ☐ Itching
- ☐ Skin Eruptions

FOR WOMEN ONLY
- ☐ Cramps or Backaches
- ☐ Hot Flashes
- ☐ Miscarriage
- ☐ Pregnant at this time

RESPIRATORY
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Spitting Blood

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Inability to Control Urine
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Prostate Trouble

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
______	Vaccinations	______	Tubes in Ears	______	Sinus
______	Tonsillectomy	______	Appendectomy	______	Hernia
______	Gall Bladder	______	Female Organs	______	Thyroid
______	Back Operation	______	Rectal Surgery	______	Stomach
______	Other ___________	______	Other ______________	______	Other ____________

☐ I have never had any operations / surgeries.

List any accidents or falls and dates: ☐ Car ________________________ ☐ Recreational Vehicle ___________________

☐ Sports __________________ ☐ School ________________________ ☐ Other ______________________________

List any broken bones (fractures) or dislocations: ____

Ever on crutches? ☐ No ☐ Yes Why? ____

Have you ever had a spinal tap(s) or spinal injection(s)? ☐ Yes ☐ No

Have you ever had X-rays taken? ☐ No ☐ Yes When? _____________ By whom? ___________________________

For what ailments were these X-rays made? ____

Do you suffer from any condition other than that for which you are now consulting us? ___________________________

Are you presently taking any medication(s) – prescription or over-the-counter? ☐ No ☐ Yes What drugs? _____________

____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare the necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any and all fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition(s) nor for any medical diagnosis.

Patient/s/Guardian's Signature X ____ Date _________________

PATIENT HISTORY

Name: ______________________________ Date: ______________

Please answer all questions thoroughly

Completion of this form helps the doctor determine what's wrong with you.
He will not see you without this form being filled out completely.

1. Please describe the location of your pain. Where does it start? Does it radiate (arm, fingers, leg, toes, back)? ______________
2. What kind of symptoms are you feeling? Please describe (pain, numbness, ache, tingling, burning, dull, sharp, mild, intense, etc.) ______________
3. When did your symptoms first appear? ______________
4. Did your symptoms appear gradually or suddenly? ______________
5. Are your symptoms constant or do they come and go? ______________
6. Have you ever had a similar episode in the past? ______________
7. Have you had any past accidents, even in childhood that may have caused injury to this area, or to your spine? Please describe. ______________
8. What might you have done to cause your symptoms? ______________
9. What makes your symptoms worse (bending, sitting, riding, etc.)? ______________
10. What makes your symptoms better (heat, cold, medication, rest)? ______________
11. What other symptoms might you have that are associated with your chief complaint (headache, nausea, dizziness, fatigue, etc.)? ______________
12. Have you seen another Doctor for this condition? If so, who? ______________
13. What was his/her diagnosis? ______________
14. What treatment did he/she prescribe? ______________
15. What was the result of this treatment? ______________
16. Please list any past surgeries. ______________
17. Please list any medications that you are presenting taking. ______________
18. Has anyone in your family had a similar problem? ______________
19. Please describe what you do in your job or occupation. ______________
20. For Women: Are you pregnant (or possibly could be)? ______________

NOTES: ______________

RECORDS TRANSFER REQUEST

Date: ____________________

To: ____

(Doctor / Hospital)

I hereby authorize the release of my xrays and records or copies of such and request that they be transferred to:

Dr. Keven M. Ellis, D.C.
Ellis Chiropractic
1302 S. Medford Drive
Lufkin, Texas 75901
936-639-1488
936-639-5064 (fax)

____________________________________ ____________________________________

Print name of Patient **Signature (patient, parent or guardian)**

NOTICE OF PRIVACY PRACTICES

Dr. Keven M. Ellis, D.C.
1302 South Medford Drive • Lufkin, Texas 75901
Telephone: 936-639-1488 • ellischiro@consolidated.net

THIS NOTICIE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on ______________________________ (insert today's date) and remains until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to use at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical student or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ______________________________ Birthdate ______________________________

Signature ______________________________ Date ______________________________