Welcome to Our Clinic

We're Glad You're Here

CASE HISTORY

Name _____ Age _____ Date _____ Case Number _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Cell _____ E-mail _____ Fax _____

Date of Birth _____ Sex: ___M ___F Marital Status ___S ___M ___D ___W ___ # of Children ____

Occupation _____ Employer _____ Telephone (work) _____ Ext ____

Spouse's Name _____ Spouse's Occupation _____ Cell Phone _____

Spouse's Employer _____ Spouse's Telephone (work) _____

Past Chiropractic Care ___ Yes ___ No If yes, when? _____ Doctor's Name _____

Results _____ Referred by _____

Social Security Number _____ Driver's License Number _____ State _____

Spouse's Social Security Number _____ Spouse's Driver's License Number _____

Chief Complaint 1. _____ Duration (How Long)_____ Previous Episodes _____

List Currant 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

Has the accident been reported? ___ No ___ Yes ___ To Employer ___ Auto Carrier ___ Other _____

Are you now or have you ever been disabled? (Service or Work)? ___ No ___ Yes When? _____ Why? _____

Have you retained an attorney? ___ No ___ Yes Name and Address _____

Please Mark the intensity of your pain today.

1 = NO PAIN 10 = MOST INTENSE 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, _____

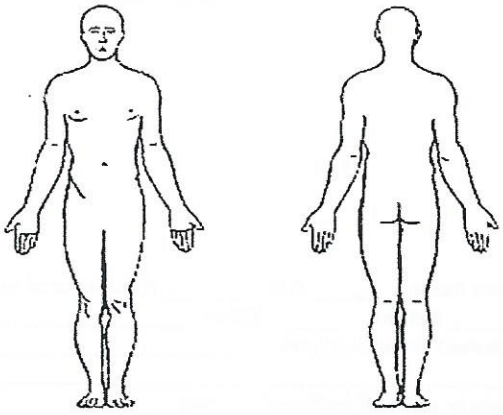
1 2 3 4 5 6 7 8 9 10

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

N – Numbness P – Pain

T – Tingling A – Ache

S – Soreness ST – Stiffness



DOCTORS USE ONLY

_____

_____

_____

_____

_____

_____

_____

HABITS

___ Smoking Packs/Day ___

___ Drinking Alcohol _____

___ Caffeine Cups/Day ___

EXERCISE

___ None

___ Light Activity

___ Moderate

___ Active

___ Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	___	___	___	___	_____
Father	___	___	___	___	_____
Brother	___	___	___	___	_____
Sister	___	___	___	___	_____

OPERATIONS AND PROCEDURES

DATE	DATE	DATE	DATE
_____ Vaccinations	_____ Tubes in Ears	_____ Sinus	_____ Tonsillectomy
_____ Gall Bladder	_____ Back Operation	_____ Appendectomy	_____ Female Organs
_____ Thyroid	_____ Other	_____ Other	_____ Other

(over)

HEALTH HISTORY:

Please indicate for each of the questions below your experience by use of the following codes: 1-never had; 2-previously had; 3 presently have.

MUSCULO-SKELETAL SYSTEM

__ Low back problems
__ Pain between shoulders
__ Neck problems
__ Arm problems
__ Leg problems
__ Swollen joints
__ Painful joints
__ Stiff joints
__ Sore muscles
__ Weak muscles
__ Walking problems
__ Ruptures
__ Broken bones

NERVOUS SYSTEM

__ Numbness
__ Loss of feeling
__ Paralysis
__ Dizziness
__ Fainting
__ Headaches
__ Muscle jerking
__ Convulsions
__ Forgetfulness
__ Confusion
__ Depression

GENITO-URINARY SYSTEM

__ Bladder Trouble
__ Excessive urination
__ Scanty urination
__ Painful urination
__ Discolored urine

FEMALE

__ Cramps
__ Excessive flow
__ Hot flashes
__ Irregular cycle
__ Miscarriages
__ Painful periods
__ Vaginal discharge
__ Vaginal pain
__ Breast pain
__ Lumps on breast

Are you pregnant?
__ Yes __ No
_____ Date of Last PAP
By whom _____

GASTRO-INTESTINAL SYSTEM

__ Poor appetite
__ Excessive hunger
__ Difficult chewing
__ Difficult swallowing
__ Excessive thirst
__ Nausea
__ Vomiting food
__ Vomiting blood
__ Abdominal pain
__ Diarrhea
__ Constipation
__ Black stool
__ Bloody stool
__ Hemorrhoids
__ Liver trouble
__ Gall bladder problems
__ Weight trouble

SKIN OR ALLERGIES

__ Bruise Easily
__ Boils
__ Dryness
__ Eczema
__ Hives or Allergy
__ Itching
__ Sensitive Skin
__ Skin Eruptions

CARDIOVASCULAR and RESPIRATORY

__ Chest Pain
__ Pain over Heart
__ Difficult Breathing
__ Persistent Cough
__ Coughing Phlegm
__ Coughing Blood
__ Rapid heart
__ Blood pressure problems
__ Heart problems
__ Lung problems
__ Varicose Veins

EYE, EAR, NOSE AND THROAT

__ Eye strain
__ Eye inflammation
__ Vision problems
__ Ear pain
__ Ear noises
__ Ear discharge
__ Hearing loss
__ Nose pain
__ Nose bleeding
__ Nose discharge
__ Difficulty breathing thru nose
__ Sore gums
__ Dental problems
__ Sore mouth
__ Sore throat
__ Hoarseness
__ Difficult speech

List any accidents or falls and dates _____ Car _____ Recreational vehicle _____ Sports _____ School _____Other_____

List any broken bones (fractures) or dislocations. _____

Ever on crutches? Why? _____

Have you had any spinal taps or spinal injections? __ Yes __ No

Were you ever knocked unconscious? __ Yes __ No Had a lapse of memory? __ Yes __ No

Have you ever had X-rays taken? __ Yes __ No When and by whom? _____

For what ailments were these X-rays made? _____

Do you suffer from any conditions other than that for which you are now consulting us? _____

Are you presently taking any medication either prescription or over-the-counter? __ Yes __ No If so, what Drugs (including vitamins) _____

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Payment is due when services are rendered.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. I understand and agree the amount paid for X-rays is for examination only and negatives will remain property of this office and may be seen at any time while a patient of this office. The doctor will not be held responsible for any pre-existing medically diagnosed condition nor for any medical diagnosis. The patient is responsible for all bills incurred at this office.

Patient's/Guardian's Signature X _____ Date _____

CHIROPRACTIC AUTHORIZATION AND RELEASE FORM

NAME _____ DATE _____ CASE # _____

I authorize release of any medical information necessary to process this claim and request payment of insurance benefits be made to **Raney Family Chiropractic Centre.**

I authorize payment of any medical benefits from _____ to be paid directly to **Raney Family Chiropractic Centre** for any service rendered to me.

I hereby give permission for my X-rays to be displayed in the treatment area.

To _____. I hereby authorize you to release to **Raney Family Chiropractic Centre** any information including the diagnosis and records, including X-rays, of any treatment or examination rendered to me during the period from: _____ to: _____.

Sent: Raney Family Chiropractic Centre
6373 S Memorial Drive, Bldg. C
Tulsa, OK 74133

Signature _____ Date: _____

Witness _____ Date: _____

CONSENT FOR TREATMENT OF MINOR CHILD:

I hereby authorize Drs. James E. and/or Bobi L. Raney and whomever they may designate as their assistants to administer Chiropractic care as they deem necessary to my _____.
(Relationship)

Name of Dependent: _____

Signature of Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

******You May Refuse to Sign This Acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please print name)

_____

(Signature)

_____

(Date)

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (Please specify)