

# CARLSBAD CHIROPRACTIC CASE HISTORY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE (HOME): \_\_\_\_\_ (MOBILE): \_\_\_\_\_ E-MAIL: \_\_\_\_\_

SOCIAL SECURITY: \_\_\_\_\_ DRIVER LIC#: \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: \_\_\_ MARITAL STATUS: M S W D NUMBER OF CHILDREN: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ YEARS EMPLOYED: \_\_\_\_\_

EMPLOYERS ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ EMPLOYER'S PHONE: \_\_\_\_\_ EXT: \_\_\_\_\_

SPOUSES NAME: \_\_\_\_\_ OCCUPATION EMPLOYER: \_\_\_\_\_

WHAT IS YOUR MAJOR COMPLAINT? \_\_\_\_\_

HOW LONG HAVE YOU HAD THIS CONDITION? \_\_\_\_\_

HAVE YOU HAS THIS OR A SIMILAR CONDITION IN THE PAST? \_\_\_\_\_

WHAT AGGRAVATES YOUR CONDITION? \_\_\_\_\_

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES  NO  CONSTANT  COMES AND GOES

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? \_\_\_\_\_

LIST SURGICAL OPERATIONS: \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS? \_\_\_\_\_ WHAT KIND? \_\_\_\_\_

OTHER DOCTORS SEEN FOR THIS CONDITION: MD  DC  DO  DDS

DOCTOR'S NAME: \_\_\_\_\_ DIAGNOSIS: \_\_\_\_\_

X-RAYS OR OTHER TAKEN? \_\_\_\_\_ WHEN: \_\_\_\_\_ RESULTS: \_\_\_\_\_

PHYSIOTHERAPY: \_\_\_\_\_ LENGTH OF TIME UNDER CARE: \_\_\_\_\_ WERE YOU OFF WORK? \_\_\_\_\_

IF SO, HOW LONG: \_\_\_\_\_

## INSURANCE INFORMATION

ARE YOU COVERED BY MEDICARE? YES  NO  MEDICARE #: \_\_\_\_\_ STATE INSURANCE AID? YES  NO

DO YOU HAVE ANY GROUP, UNION OR PERSONAL HEALTH AND ACCIDENT INSURANCE? YES  NO

NAME OF INSURANCE COMPANY: \_\_\_\_\_ POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ AGENT: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

I clearly understand and agree that all of the services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me will be immediately due and payable.

**I ALSO AGREE TO PAY AND COLLECTION FEES ASSOCIATED WITH MY BILL INCURRED AT THIS OFFICE.**

Patient's Name: \_\_\_\_\_

Medicare#(HICN): \_\_\_\_\_

**ADVANCE BENEFICIARY NOTICE (ABN)**

**NOTE: You need to make a choice about receiving these health care items or services.**

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for—**

**Items or services:**

99201-99205 office visit	99385-99412 preventive services
99211-99215 office visit	97010-97039 modalities
98943 CMT extraspinal	97110-97140 therapeutic procedures
99241-99245 consultation	71020-72190 x-rays

**Because:**

Non-covered Services

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

. Ask us to explain, if you don't understand why Medicare probably won't pay.

. Ask us how much these items or services will cost you (Estimated Cost :\$ \_\_\_\_\_), in case you have to pay for them yourself or through other insurance.

**PLEASE CHOOSE ONE OPTION. CHECK ONE. SIGN & DATE YOUR CHOICE**

     **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

     **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or person acting on patient's behalf

**Note: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

# SYMPTOM SURVEY

NAME \_\_\_\_\_

DATE \_\_\_\_\_

<p><b>1. GENERAL SYMPTOMS: (Circle as many as apply)</b></p> <p>A) Nervousness   B) Irritability   C) Fatigue   D) Depression                      E) Loss of Sleep   F) Tension   G) PMS   H) Jaw Pain</p> <p><b>2. HEAD: (Circle as many as apply)</b></p> <p>A) Headache   1) Mild   2) Moderate   3) Severe</p> <p>How often:   ( 1 2 3 4 5 6 7 )   Per (Day/Wk/ Mo)</p> <p>Are they:   1) Sharp   2) Dull                      Are they:   1) Constant   2) Intermittent</p> <p>Where Located:   1) Back of Head   2) Forehead                      3) Temple   4) Right Side                      5) Left Side   6) Behind Eyes</p> <p>B) Light Headed   C) Memory Loss   D) Fainting                      E) Blurred Vision   F) Double Vision   G) Sensitivity to Light                      H) Loss of Balance   I) Hearing Loss   J) Ringing in Ears</p> <p><b>3. NECK: (Circle as many as apply)</b></p> <p>A) Pain   1) Left Side   2) Right Side   3) Both</p> <p>Pain Level   1) Mild   2) Moderate   3) Severe</p> <p>Pain Increased by:   1) Forward Movement                      2) Backward Movement                      3) Rotate Head Rt   4) Rotate Head Lt                      5) Bend Neck Rt   6) Bend Neck Lt</p> <p>B) Stiffness   C) Muscle Spasm   D) Grinding/Grating Sounds</p> <p><b>4. SHOULDERS: (Circle as many as apply)</b></p> <p>A) Pain in Joint   1) Left   2) Right   3) Both                      B) Pain Across Shoulder   1) Left   2) Right   3) Both                      C) Limitation of Movement   1) Left   2) Right   3) Both                      D) Tension   1) Left   2) Right   3) Both</p> <p><b>5. ARMS: (Circle as many as apply)</b></p> <p>A) Pain in Upper Arm   1) Left   2) Right   3) Both                      B) Pain In Elbow   1) Left   2) Right   3) Both                      C) Pain in Forearm   1) Left   2) Right   3) Both                      D) Pins &amp; Needles (Arm)   1) Left   2) Right   3) Both                      E) Pins &amp; Needles (Forearm)   1) Left   2) Right   3) Both                      F) Numbness in Arm   1) Left   2) Right   3) Both                      G) Numbness in Forearm   1) Left   2) Right   3) Both</p> <p><b>6. HANDS: (Circle as many as apply)</b></p> <p>A) Pain in Wrist   1) Left   2) Right   3) Both                      B) Pain in Hand   1) Left   2) Right   3) Both                      C) Pins &amp; Needles (Hand)   1) Left   2) Right   3) Both                      D) Numbness (Hand)   1) Left   2) Right   3) Both</p>	<p><b>7. MIDBACK: (Circle as many as apply)</b></p> <p>A) Pain   1) Left   2) Right   3) Both</p> <p>Pain Level   1) Mild   2) Moderate   3) Severe</p> <p>Pain Type   1) Sharp/Stabbing   2) Dull Ache</p> <p>B) Muscle Spasm   1) Left   2) Right   3) Both</p> <p><b>8. CHEST: (Circle as many as apply)</b></p> <p>A) Deep Chest Pain   1) Left   2) Right   3) Both</p> <p>Pain Level   1) Mild   2) Moderate   3) Severe</p> <p>B) Pain Around Ribs   1) Left   2) Right   3) Both                      C) Shortness of Breath                      D) Irregular Heartbeat</p> <p><b>9. ABDOMINAL SYMPTOMS: (Circle as many as apply)</b></p> <p>A) Pain   1) Mild   2) Moderate   3) Severe                      B) Nervous Stomach   C) Heartburn   D) Gas   E) Constipation                      F) Diarrhea   G) Nausea   H) Indigestion   I) Loss of Appetite</p> <p><b>10. LOWBACK: (Circle as many as apply)</b></p> <p>A) Upper Lumbar Pain   1) Left   2) Right   3) Both                      B) Lower Lumbar Pain   1) Left   2) Right   3) Both                      C) Sacroiliac Pain   1) Left   2) Right   3) Both                      D) Muscle Spasm   1) Left   2) Right   3) Both</p> <p>Low Back Pain Level   1) Mild   2) Moderate   3) Severe</p> <p><b>11. HIPS AND LEGS: (Circle as many as apply)</b></p> <p>A) Pain in Buttocks   1) Left   2) Right   3) Both</p> <p>Pain Level   1) Mild   2) Moderate   3) Severe</p> <p>B) Pain in Hip Joint   1) Left   2) Right   3) Both</p> <p>Pain Level   1) Mild   2) Moderate   3) Severe</p> <p>C) Pain Down Leg   1) Left   2) Right   3) Both</p> <p>Location   1) Front   2) Back   3) Side</p> <p>Pain Radiates to   1) Knee   2) Calf   3) Foot</p> <p>D) Numbness Down Leg   1) Left   2) Right   3) Both</p> <p>Location   1) Front   2) Back   3) Side</p> <p>E) Pins &amp; Needles (Legs)   1) Left   2) Right   3) Both</p> <p>Location   1) Front   2) Back   3) Side</p> <p>F) Knee Pain Leg   1) Left   2) Right   3) Both                      G) Leg Cramps   1) Left   2) Right   3) Both</p> <p><b>12. FEET: (Circle as many as apply)</b></p> <p>A) Ankle Pain   1) Left   2) Right   3) Both                      B) Swollen Ankle   1) Left   2) Right   3) Both                      C) Foot Pain   1) Left   2) Right   3) Both                      D) Numbness of Feet   1) Left   2) Right   3) Both                      E) Swollen Feet   1) Left   2) Right   3) Both                      F) Cramps   1) Left   2) Right   3) Both</p>
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