

Gabel Chiropractic
PATIENT CASE HISTORY

Date: _____

Name: _____ Sex: M F DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ email address: _____

Cell Phone: _____ Marital Status: M S W D Spouse's Name: _____

Insurance Policy Holder: _____ Insurance Policy Holder's DOB: _____

Insurance Policy's SS#: _____

CHIEF COMPLAINT/REASON FOR THIS APPOINTMENT:

1. _____

Additional problems or concerns you would like to address:

2. _____

3. _____

What treatment have you already had for these conditions:

Were x-rays taken? If yes, where?

Is this condition due to a: Auto Accident Work Injury Other Accident Illness Unknown
 Other _____

How long have you had this complaint? _____

Circle the intensity of pain: (0 = no pain, 10 = worst pain) 0 1 2 3 4 5 6 7 8 9 10

Are symptoms generally... Improving Getting Worse About the Same Intermittent (comes & goes)

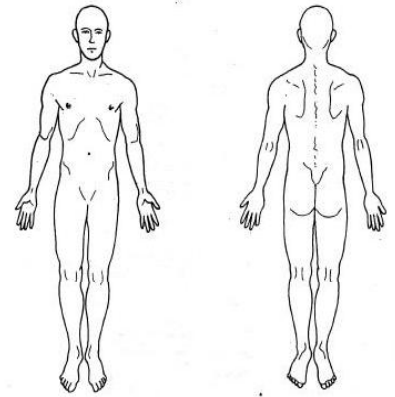
Does this pain radiate or travel to a different area of the body? No Yes, it travels _____

Have you had similar symptoms before? No Yes When? _____

Have you lost time from work? No Yes Dates lost: _____

Date returned to work: _____ Dr. Ordered? No Yes Self Determined? No Yes

Effect on Daily Activities? No Effect Extra Effort Required Occasional Limitation Frequent or Severe Limitation



(Mark your areas of complaint)

PAST MEDICAL HISTORY

Aids, HIV Alcoholism Allergy
Arthritis Asthma Cancer
Cholesterol Depression Diabetes
Epilepsy Heart Disease Hepatitis
Herniated Disk Pacemaker Pinched Nerve
Thyroid Tuberculosis Tumors
High Blood Pressure

Other Illnesses: _____

Surgery: _____

Other Injuries/accidents: _____

SOCIAL HISTORY

Education Level Completed: _____

Children (list ages): _____

Major Stress in the last 6 months? _____

YOUR HEALTH CARE TEAM

Family Physician: _____ Phone: _____

Other Specialist: _____ Phone: _____

Have you ever seen:

Chiropractor Name: _____

Acupuncture Name: _____

Massage therapist Name: _____

LIFE STYLE / SELF-CARE ISSUES

- Have you smoked cigarettes? Yes No
___ packs/day, smoked for ___ years
- Do you still smoke? Yes No
- Do you drink caffeinated beverages? Yes No
___ cups, cans/day
- Do you drink alcohol? Yes No
___ number of drinks/week
- Do you exercise regularly? Yes No
Type, Frequency _____
- Do you sleep soundly? Yes No
- Is your diet healthy enough? Yes No
 Not Sure Need Help

DIET HABITS

- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Snacks: _____
- Fluids: cups of water _____ other fluids _____

CURRENT MEDICATIONS

Dosage Times/day

_____**CURRENT HERBS/ VITAMINS**

Dosage Times/day

REVIEW OF SYSTEMS:**Please check areas of concern.****Constitutional**

- ___ decreased sleep
- ___ irregular sleep
- ___ excessive sleep
- ___ poor appetite
- ___ fever
- ___ chills
- ___ weight loss
- ___ weight gain
- ___ fatigue

Immune System

- ___ too many infections
- ___ allergies to food or environment
- ___ other concerns

Mood, Thoughts, and**Emotions**

- ___ manic episodes
- ___ energy problems
- ___ depression
- ___ panic attacks
- ___ anxiety, over stressed

Skin, Hair, Breast

- ___ breast lumps or pain
- ___ breast leaks fluid
- ___ rashes
- ___ itching, hives
- ___ hair loss
- ___ mole changes
- ___ dry skin, eczema

Ears, Nose, Mouth, Throat

- ___ ringing ears
- ___ nose bleeds
- ___ postnasal drip
- ___ sinus problems
- ___ trouble with taste/smell
- ___ poor hearing
- ___ earaches
- ___ headaches
- ___ facial pain
- ___ jaw clicks
- ___ grinding teeth
- ___ sore throat
- ___ mouth sores

Eyes

- ___ eye pain
- ___ blurred vision
- ___ poor vision ___ day ___ night
- ___ wear corrective lenses
- ___ near sighted
- ___ far sighted

Heart & Circulation

- ___ chest pain
- ___ lightheadedness
- ___ palpitations
- ___ cold hands/feet
- ___ fainting
- ___ swelling feet
- ___ blood clots
- ___ varicose veins

Digestion and Intestines

- ___ indigestion
- ___ belching
- ___ difficulty swallowing
- ___ heartburn
- ___ nausea
- ___ liver trouble
- ___ vomiting
- ___ blood in stools
- ___ diarrhea
- ___ foods that upset your system
- _____
- ___ cramping bowels
- ___ constipation

Nerves, movement, brain

- ___ seizures
- ___ nerve pains
- ___ poor balance
- ___ poor coordination
- ___ tremors or shaking
- ___ numbness
- ___ dizziness
- ___ poor memory
- ___ trouble sleeping

Muscles, Bones & joints

- ___ neck pain
- ___ back pain
- ___ muscle pain
- ___ muscle weakness
- ___ muscle cramps
- ___ joint swelling
- ___ painful joints
- ___ shoulder ___ elbow
- ___ hip ___ knee ___ ankle
- ___ foot ___ toe ___ hand
- ___ wrist ___ fingers

Urine, Kidneys, Bladder

- ___ decreased urine flow
- ___ blood or pus in urine
- ___ painful urination
- ___ wake up to urinate
- ___ kidney stones
- ___ loss of control of urine
- ___ sudden urges to urinate
- ___ frequent urination

Women's Reproductive

- ___ age period started
- ___ number of pregnancies
- ___ pregnancies lost
- ___ past fertility problems
- ___ number of live births
- ___ children currently living
- ___ age period stopped, menopause

Sexual Organs

- ___ erection problems
- ___ infertility
- ___ repeated infections
- Women:
 - ___ pelvic pain
 - ___ vaginal discharge
 - ___ painful periods
 - ___ premenstrual syndrome
 - ___ hot flashes
 - ___ itching or soreness

Gabel Chiropractic Financial Policy

INSURANCE

If you have health insurance we will need a copy of your insurance card. We will verify your benefits and once they are verified we will then submit your claims on a timely basis.

You are responsible for paying co-payment and non-covered supplements and supplies at the time they are rendered. Deductible and co-insurance will be billed once we have received an explanation of benefits from your insurance company. If you are being seen more than once a week arrangements can be made to pay your portion at the last visit of the week or you can have the payment made by using your credit card.

OR

If you wish to bill your insurance, we ask you pay 100% of your services at the time of each visit. We will provide you with a receipt with the necessary billing information, which you can send your insurance carrier for reimbursement.

NON-INSURED

We request 100% of the first visit be paid at the time of the first visit. All future visits are to be paid on a weekly basis.

WORKER'S COMPENSATION

Chiropractic services are covered by Worker's Compensation Law, and you should be covered 100%, as long as your employer is aware you were injured on the job, you have completed the required papers with your employer, and your employer has no objection to your receiving care here, and is covered by Worker's Compensation insurance. You are responsible for non-covered items such as supplements and supports that are not a direct result of the accident. These items are to be paid for at the time they are received.

IT MUST BE UNDERSTOOD:

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

_____ I have Iowa Medicaid

_____ I have Medicare, and I understand that Medicare does not pay for examinations. Therefore, I will be responsible for such charges.

_____ I have health insurance that covers chiropractic care.

_____ I do not have health insurance and I will pay at time of service.

_____ I have been injured at work and will furnish all the necessary information to Dr. Gabel and staff.

_____ I have been injured in an auto accident. I will furnish all information to bill for this accident

Guarantor Signature

Date

GABEL CHIROPRACTIC
ADULT AUTHORIZATION
INFORMED CONSENT UNDER IOWA CODE SECTION 147.137

INTRODUCTION

The profession of chiropractic, dentistry, medicine and surgery, nursing, optometry, osteopathy, osteopathic medicine and surgery, pharmacy, physical therapy, podiatry, psychology, and other are regulated in the state of Iowa under Iowa Code Chapter 147. Patient care provided by those above listed professions, including chiropractic, have known risks which may include death, brain damage, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars associated with such care and treatment. For your information, the following is routinely furnished to all who consider chiropractic care at this clinic.

Gabel Chiropractic is staffed with a licensed doctor of chiropractic. Chiropractic is a science, which concerns itself with relationship between structure (primarily the spine) and function (primarily the spine) of the body as the relationship may effect the restoration and preservation of health.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, laboratory tests, radiology examinations, physical therapy and related rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession -- the chiropractic spinal adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s).

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome (VAS), including stroke and perhaps, death through complicating factors.

AUTHORIZATION FOR CHIROPRACTIC CARE OF A MINOR OR PERSON UNABLE TO CONSENT

I have been informed of the nature and purpose of chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE PRECEEDING PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS, WHICH I HAVE ASKED, HAVE BEEN ANSWERED TO MY SATISFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. ANGELA GABEL TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED _____, CLINTON, IOWA

PATIENT'S SIGNATURE

DOCTOR'S SIGNATURE

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax to this number
<hr/> <input type="checkbox"/> Other _____
<hr/> |
| <input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | |

_____ Patient Signature

_____ Date

_____ Print Name

_____ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency .

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
 (2) Type key: T=Treatment Records. P=Payment Information. O=Healthcare Operations
 (3) Enter how disclosure was made: F=fax P=Phone E=Email M=Mail 0=Other