Gabel Chiropractic Today's Date: _____

EXPECTANT PATIENT CASE HISTORY

First Name: _____ Last Name: _____ MI: ____ Nickname: _____

DOB: _____ Sex: M F SS#:_____

Email address: _____

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

Primary Phone Contact: _____ Type: Cell phone Home Phone Work Phone

Secondary Phone Contact: _____ Type: Cell phone Home Phone Work Phone

Job Status: Not Employed Employed Part Time Student Full Time Student

Marital Status: Single Married Referred by: _____

REMINDER: _____Phone call _____ Text Message; Cell Phone Carrier _____(Required for Text)

Hand Dominance: _____ ambidextrous _____ Right _____ Left

Race: _____ white _____ black or African American _____ American Indian or Native American _____ Asian _____ Other

Smoking Status: _____ Current smoker _____ Occasional smoker _____ Former Smoker _____ Never Smoked

Daily Caffeinated Beverages: _____ none _____ 1-3 _____ 4-6 _____ 7-10 _____ 11-15

Weekly Alcoholic Beverages: _____ none _____ 1-3 _____ 4-6 _____ 7-10 _____ 11-15

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

Insurance Policy's#:_____ **Date of Last Menstrual Cycle: _____**

Due Date: _____ **Birth care Provider: _____**

Will you be finding out the sex? _____ yes _____ no **We are having a: ____ boy _____ girl**

Medications/Vitamins: _____ **Allergies: _____**

_____ _____

_____ _____

Surgeries: _____ **Injuries: _____**

_____ _____

_____ _____

PAST MEDICAL HISORY

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

SOCIAL HISTORY

Education Level Completed: _____

Children (list ages): _____

Major Stress in the last 6 months? _____

_____

YOUR HEALTH CARE TEAM
Family Physician: _____
Other Specialist: _____

Have you ever seen:
□ Chiropractor Name: _____
□ Acupuncture Name: _____
□ Massage therapist Name: _____

CHIEF COMPLAINT/REASON FOR THIS APPOINTMENT: _____
Pain began: gradually suddenly
Does this pain radiate or travel to a different area of the body? _____ no _____ yes, it travels _____

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

Describe the Pain: _____
How long have you had this complaint? _____ 1 day _____ 2 days _____ 3 days _____ several days _____ weeks _____ months

Do you notice pain any certain time of the day? _____

Do you know what caused the problem? _____

Is the pain: _____ constant _____ come and go Is the pain: _____ getting better _____ getting worse _____ same

Has anything you have done so far helped the problem? (ie. Ice, ibuprofen, rest) _____

What makes the problem worse? _____

Have you sought any other doctor/treatment for this condition: _____ no _____yes ; Who have you seen? _____

Were x-rays taken? _____ yes _____ no If yes, where? _____

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

Effects on Daily Activities? _____ No Effect _____ Extra Effort Required _____Occasional Limitation _____Frequent or Severe Limitation

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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

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

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 AN ADULT

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 NFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS, WHICH I HAVE ASKED, HAVE BEEN ANSWERED TO MY SATIFACTION.

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

DATED _____, CLINTON, IOWA

_____

PATIENT'S SIGNATURE

_____

DOCTOR'S SIGNATURE

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

_____ 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 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

PATIENT PRIVACY POLICY

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 be 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):

□ Home phone_____ _____
- □ Leave a message with detailed information
- □ Leave a message with call-back number only

□ Written Communication
- □ Mail to my home address
- □ Mail to my work address

_____

- □ Fax to this number

_____

□ Cell phone _____
- □ Leave a message with detailed information
- □ Leave a message with call-back number only
- □ Text a message

□ Other _____

_____

I would prefer to be reminded of my appointment by:
- □ Calling my home phone
- □ Calling my cell phone
- □ Text message to my cell phone

_____ _____

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 and individual.