

Gabel Chiropractic
PATIENT CASE HISTORY

Today's Date: _____

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

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

Email address: _____

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

Primary Phone Contact: _____ Type: Cellphone Home Phone Work Phone

Secondary Phone Contact: _____ Type: Cellphone 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 #: _____

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 Whom 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

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

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
MINOR AUTHORIZATION FORM
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

A: PATIENT IS A MINOR _____ YEARS OF AGE

B: OTHER _____

PATIENT'S NAME: _____

PERSON AUTHORIZED TO SIGN FOR PATIENT: _____

Signature of authorized person

RELATIONSHIP TO PATIENT: _____

SIGNATURE OF DOCTOR: _____

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):

- | | |
|---|---|
| <input type="checkbox"/> Home phone _____
<input type="checkbox"/> Leave a message with detailed information
<input type="checkbox"/> Leave a message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> Mail to my home address
<input type="checkbox"/> Mail to my work address

<input type="checkbox"/> Fax to this number
_____ |
| <input type="checkbox"/> Cell phone _____
<input type="checkbox"/> Leave a message with detailed information
<input type="checkbox"/> Leave a message with call-back number only
<input type="checkbox"/> Text a message | <input type="checkbox"/> 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.