

CASE HISTORY

Date _____ E-mail _____
 Name _____ Phone (Home) _____ Date of Birth _____
 Address _____ Age _____ Sex: M F
 Marital Status: S M D W
 Occupation _____ Employer _____ Telephone (Work) _____
 Spouse's Name _____ Spouse's Occupation _____
 Spouse's Employer _____ Spouse's Telephone (Work) _____
 Referred By _____ Past Chiropractic Care Yes No When _____
 Doctor's Name _____ Results _____
 Chief Complaint _____
 Social Security # _____

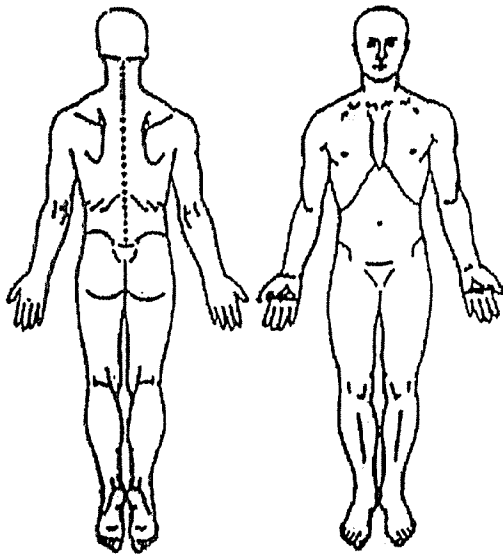
Are your symptoms: Improving Getting Worse Come and Go Same
 Have you had these symptoms before? Yes No How long ago? _____
 What aggravates your condition? Standing/Walking Sitting Twisting/Coughing Bending
 Have you done anything at home for this? Yes No Describe: _____
 Are your present problems due to an injury? Yes No On the job Auto Accident Personal Injury Other
 If yes, have you made a report of your accident? Yes No To Employer Auto Carrier Other _____
 Are you now or have you ever been disabled? (Service or Work?) No Yes When _____
 Have you retained an attorney? Yes No Name and Address _____

PLEASE MARK AREA OF PAIN ON THE DRAWING USING THE CODES LISTED

Mark Pain Area
 ++++ Burning
 000 Stabbing
 --- Sharp

SEVERITY OF PAIN

List region of pain and circle severity number.
 (1=least, 10=greatest)



III Constant

ex. Neck
 1 2 3 4 5 6 7 8 9 10

Please list in order of severity.

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

4. _____
 1 2 3 4 5 6 7 8 9 10

5. _____
 1 2 3 4 5 6 7 8 9 10

HABITS

Smoking Packs/Day _____
 Drinking Alcohol _____
 Coffee Cups/Day _____

EXERCISE

None
 Moderate
 Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, No. of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ 541 Appendicitis	___ 280 Anemia	___ 429.9 Heart Disease	___ 716 Arthritis
___ 480 Pneumonia	___ 055 Measles	___ 240 Goiter	___ 345 Epilepsy
___ 390 Rheumatic Fever	___ 072 Mumps	___ 487 Influenza	___ 319 Mental Disorder
___ 045 Polio	___ 052 Chicken Pox	___ 511 Pleurisy	___ 724.2 Lumbago
___ 011 Tuberculosis	___ 250 Diabetes	___ 305.0 Alcoholism	___ 690 Eczema
___ 033 Whooping Cough	___ 239 Cancer	___ 099 Venereal Disease	___ 044 AIDS

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable. A complete history and understanding of you health will facilitate care.

GENERAL SYMPTOMS		GASTRO-INTESTINAL		EYE/EAR/NOSE/THROAT		RESPIRATORY	
___ 784.0	Headache	___ 783	Poor Appetite	___ 368.9	Poor Vision	___ 786.2	Chronic Cough
___ 780.6	Fever	___ 536.8	Poor Digestion	___ 378.9	Crossed Eyes	___ 786.3	Spitting Blood
___ 780.9	Chills	___ 994.2	Excessive Hunger	___ 379.91	Pain in Eyes	___ 933.1	Spitting Phlegm
___ 780.8	Night Sweats	___ 787.3	Belching or Gas	___ 389.9	Deafness	___ 786.50	Chest Pain
___ 780.2	Fainting	___ 787	Nausea	___ 388.70	Earache	___ 786.09	Difficulty Breathing
___ 780.4	Dizziness	___ 787	Vomiting	___ 388.30	Ear Noises		
___ 780.3	Convulsions	___ 578	Vomiting Blood	___ 388.60	Ear Discharges		
___ 780.52	Loss of Sleep	___ 536.8	Pain over Stomach	___ 478.1	Nasal Obstruction		
___ 780.7	Fatigue	___ 564	Constipation	___ 784.7	Nose Bleeds		
___ 799.2	Nervousness	___ 558.9	Diarrhea	___ 462	Sore Throats	GENITO-URINARY	
___ 783	Loss of Weight	___ 789	Colon Trouble	___ 784.49	Hoarseness	___ 788.3	Frequent Urination
___ 782	Numbness or pain in arms/legs/hands	___ 455.6	Hemorrhoids (Piles)	___ 477.9	Hay Fever	___ 788.1	Painful Urination
___ 995.3	Allergy (What)	___ 785.1	Liver Trouble	___ 493.9	Asthma	___ 599.7	Blood in Urine
___ 786.09	Wheezing	___ 782.4	Jaundice	___ 460	Frequent Colds	___ 592	Kidney Infection
___ 729.2	Neuralgia	___ 575.9	Gall Bladder Trouble	___ 240.9	Enlarged Thyroid	___ 788.3	Bed Wetting
				___ 463	Tonsillitis	___ 788.1	Inability to control Urine
				___ 686.9	Sinus Trouble	___ 601.9	Prostate Trouble
MUSCLES & JOINTS		CARDIO-VASCULAR		SKIN OR ALLERGIES		FOR WOMEN ONLY	
___	Weakness	___ 783	Rapid Heart	___ 368.9	Skin Eruptions	___ 786.2	Painful Periods
___	Twitching	___ 427.89	Slow Heart	___ 698.9	Itching	___ 626.2	Excessive Flow
___ 847	Stiff Neck	___ 401.9	High Blood Pressure	___ 278.8	Bruising Easily	___ 626.4	Irregular Cycle
___ 722.10	Backache	___ 458.9	Low Blood Pressure	___ 701.1	Dryness	___ 627.2	Hot Flashes
___ 719	Swollen Joints	___ 786.51	Pain over Heart	___	Boils	___ 625.3	Cramps or Backaches
___ 781	Tremors	___ 438	Previous Heart Trouble	___ 782	Sensitive Skin	___ 634.9	Miscarriage
___ 729.5	Foot Trouble	___ 719.07	Swelling Ankles	___ 708.9	Hives or Allergy	___ 623.5	Vaginal Discharge
___ 724.79	Painful Tail Bone	___ 759.9	Poor Circulation	___ 692.9	Eczema	___	Pregnant at this Time
___ 724.5	Pain Between Shoulders	___	Varicose Veins	___	Medicines	___	Last Pap
___ 563.3	Hernia	___ 436	Strokes	___	___	By Whom	___
___ 737.3	Spinal Curvature			___	___	Other	___

OPERATIONS AND PROCEDURES

DATE	Vaccinations	DATE	Tubes in Ears	DATE	Sinus
___	Tonsillectomy	___	Appendectomy	___	Hernia
___	Gall Bladder	___	Female Organs	___	Thyroid
___	Back Operation	___	Rectal Surgery	___	Stomach
___	Other	___	Other	___	Other
___	___	___	___	___	___
___	___	___	___	___	___

List any accidents or falls and dates: Car _____ Recreational Vehicle _____ Sports _____
 School _____ Other _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? No Yes Why? _____

Have you ever had any spinal taps or spinal injections? Yes No Were you ever knocked unconscious? Yes No

Have you ever had a lapse of memory? Yes No

Have you ever had X-rays taken? No Yes When? _____ By whom? _____

For what ailments were these X-rays made? _____

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

Are you presently taking any medication - prescription or over-the-counter? No Yes What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X _____ **Date** _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Milostan Chiropractic's "Notice of Privacy Practices" had been provided to me.

I understand I have a right to review Milostan Chiropractic's Notice of Privacy Practices prior to signing this document. Milostan Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Milostan Chiropractic. The notice of Privacy Practices for Milostan Chiropractic's is also provided on request at the main administration desk of this practice and on Milostan Chiropractic's Website at www.greaterhealthinfo.com This notice of privacy Practices also describes my rights and Milostan Chiropractic's duties with respect to my protected health information.

Milostan Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices, I may obtain a revised notice of privacy that ate described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Milostan Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Milostan Chiropractic

2400 Union Lake Road, Commerce Township, MI 48382
Phone: (248) 360-4333 Fax: (248) 360-9457

Insurance Coverage/ Patient Responsibility

Milostan Chiropractic will find out as accurately as possible your chiropractic coverage. Due to constant changes in insurance coverage, it is no longer an easy job to interpret each individual policy. Although we always try to stay aware of changes, it is not always possible.

It is your responsibility, as the policy holder, to know your individual coverage. It is also your responsibility to make sure we have the correct insurance information/card at every visit.

PLEASE do not get frustrated with us if your insurance does not cover our services. All insurance policies have exclusions/limitations and most have deductibles and co-payments. Sometimes we do not know your copay/coinsurance/deductible amounts until we hear back from your insurance. Please note you are responsible for any and all of those amounts. Please remember your insurance policy/coverage is an agreement between you and your insurance company **NOT** between Milostan Chiropractic and your insurance company.

You will be responsible for the cost for care that you have received if your insurance determines that it is not a covered benefit related to a regular health claim or an auto insurance claim. If you are pursuing legal action or decide later to file and gain payment for care related to an injury, you are responsible to pay Milostan Chiropractic and be reimbursed from your settlement once it has been determined.

Patient/Guardian Signature

Date