

Alliance Chiropractic and Massage
Confidential Case History

How did you hear about us? _____

Date: _____

Patient Information

Name: _____ Male Female
(First) (Initial) (Last) (Name Called by)

Address: _____ City _____ State _____ Zip _____
Date of birth: _____ Social Security #: ____/____/____
Occupation: _____ Full Time Part Time Retired Employer: _____
 Single Married Divorced Widowed Separated Spouses Name: _____
of Children _____
Cell Phone: _____ Work Phone: _____ Email: _____
Parents Name (if a minor) _____ Parents Phone # _____

Emergency Contact

Name: _____ Relationship: _____ Cell Phone: _____
Can we release information to this person? Yes No

Patient Conditions

What is your major symptom/problem? _____

When did your symptoms begin? _____

How did your symptoms begin? _____

Have you had this problem before? Yes No

Is your condition getting worse? Yes No

Do your symptoms radiate into: Arms Legs None Other _____

Is this problem: Constant Comes & Goes

How does it feel? Burning Sharp Shooting Dull

Tingling Swelling Throbbing

Other: _____

Circle the severity of the pain on a 0 to 10 scale:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____

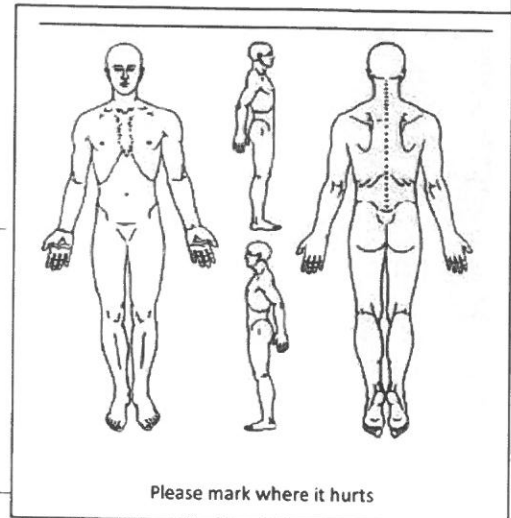
What makes your condition worse? _____

What other treatments have you had for this condition? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities/Movements that are painful to perform: Lying down Standing Walking Sitting
 Bending Getting up Driving Reading

Have there been any changes in your bodily functions? Yes No (if yes, what?) _____



Alliance Chiropractic and Massage
Confidential Case History

Family History:	Back	Heart	Stroke	Cancer	Diabetes	High Bp
Mother:	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
No. of sisters: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No. of brothers: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:	> 3x/wk	3x/wk	2x/wk	1x/wk	2x/mo	1x/mo	Never
Standing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit at a desk:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work at computer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work on a phone:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mod/Heavy labor:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stay at home:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deliver Packages:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco/Smoke:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholic drinks:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Accident History: Enter all auto accidents, slips & Falls, Sports or work related injuries that you had in the past.

Accident Type:	Date:	Chiropractic Treatment Received
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Auto <input type="checkbox"/> Sports Related <input type="checkbox"/> Work Related <input type="checkbox"/> Major Slip & Fall	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>Main Reason for consulting this office:</p> <input type="checkbox"/> Become pain free <input type="checkbox"/> Explanation of my condition <input type="checkbox"/> Learn how to care for my condition <input type="checkbox"/> Reduce symptoms <input type="checkbox"/> Resume normal activity level	<p>Females:</p> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last menstrual cycle: _____	<p>Sleep positions:</p> <input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> Stomach Do you wear heel lifts? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	--

Surgical History: List any surgical procedures you have had:

Surgery Name: _____	Date Performed: _____
Surgery Name: _____	Date Performed: _____

Alliance Chiropractic and Massage
Confidential Case History

Allergies: Environmental or Medical Allergies

Allergy Name: _____ Date Detected: _____
Allergy Name: _____ Date Detected: _____

Current Medications/Supplements

Rx Name: _____ Reason: _____
Rx Name: _____ Reason: _____

Past or Previous Conditions List:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Alcohol/Drug Addiction | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Backaches | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Collagen Vascular Disease | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Female Health Challenges |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gluten Intolerance |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Heart attach/Attacks |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Joint/Back Pain | <input type="checkbox"/> Kidney Infections |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Liver Disease/Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Migraines | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Reflux/Ulcers | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Stress/Tension | <input type="checkbox"/> Stroke | <input type="checkbox"/> Suicidal Tendencies | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Urine Discoloration | <input type="checkbox"/> Vertigo |

Authorization

Insurance verification and authorization are not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Alliance Chiropractic and Massage/Jeffrey Scott Ruth, D.C. to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

Signature

Date

Parent (if patient is a minor)

Functional Rating Index

For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

<p>1. Pain Intensity</p> <p>0 1 2 3 4</p> <p>No pain Mild pain Moderate pain Severe pain Worst possible pain</p>	<p>6. Recreation</p> <p>0 1 2 3 4</p> <p>Can do all activities Can do most activities Can do some activities Can do a few activities Cannot do any activities</p>
<p>2. Sleeping</p> <p>0 1 2 3 4</p> <p>Perfect sleep Mildly disturbed sleep Moderately disturbed sleep Greatly disturbed sleep Totally disturbed sleep</p>	<p>7. Frequency of pain</p> <p>0 1 2 3 4</p> <p>No pain Occasional pain; 25% of the day Intermittent pain; 50% of the day Frequent pain; 75% of the day Constant pain; 100% of the day</p>
<p>3. Personal Care (washing, dressing, etc.)</p> <p>0 1 2 3 4</p> <p>No pain; no restrictions Mild pain; no restrictions Moderate pain; need to go slowly Moderate pain; need some assistance Severe pain; need 100% assistance</p>	<p>8. Lifting</p> <p>0 1 2 3 4</p> <p>No pain with heavy weight Increased pain with heavy weight Increased pain with moderate weight Increased pain with light weight Increased pain with any weight</p>
<p>4. Travel (driving, etc.)</p> <p>0 1 2 3 4</p> <p>No pain on long trips Mild pain on long trips Moderate pain on long trips Moderate pain on short trips Severe pain on short trips</p>	<p>9. Walking</p> <p>0 1 2 3 4</p> <p>No pain; any distance Increased pain after 1 mile Increased pain after 1/2 mile Increased pain after 1/4 mile Increased pain with all walking</p>
<p>5. Work</p> <p>0 1 2 3 4</p> <p>Can do usual work plus unlimited extra work Can do usual work; no extra work Can do 50% of usual work Can do 25% of usual work Cannot work</p>	<p>10. Standing</p> <p>0 1 2 3 4</p> <p>No pain after several hours Increased pain after several hours Increased pain after 1 hour Increased pain after 1/2 hour Increased pain with any standing</p>

Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED _____ Date _____ Signature _____

HEALTHCARE AUTHORIZATION FORM

Patients Name: _____

Patients S.S. #: _____ Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ALLIANCE CHIROPRACTIC AND MASSAGE TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- I give permission to Alliance Chiropractic and Massage to use my address, phone number, e-mail and clinical records to contact me with birthday cards, holiday related cards and information about treatment alternatives or other health related information.
- I give Alliance Chiropractic and Massage permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Alliance Chiropractic and Massage permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this **AUTHORIZATION**, in writing at any time. However, your written request to revoke this **AUTHORIZATION** is not effect to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this **AUTHORIZATION** by mailing or hand delivering a written notice to the Privacy Official of Alliance Chiropractic and Massage. The written notice must contain the following information:

- ❖ Your name, Social Security number and date of birth;
- ❖ A clear statement of your intent to revoke this **AUTHORIZATION**;
- ❖ The date of your request; and
- ❖ Your signature.

The revocation is not in effect until it is received by the Privacy Official.

This **AUTHORIZATION** is requested by Alliance Chiropractic and Massage for its own use/disclosure of PHI. (Minimum necessary standards apply.) You have the right to refuse to sign this **AUTHORIZATION**. If you refuse to sign this **AUTHORIZATION**, Alliance Chiropractic and Massage will not refuse to provide treatment. You have the right to inspect or copy the PHI to be used /disclosed.

***** A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU*****

PRINT NAME OF PATIENT: _____

SIGNATURE OF PATIENT: _____

DATE: _____

Signature of Personal Representative: _____

Description of Representative's Authority to Act for Patient: _____

**INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC**

CHIROPRACTIC- It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS- A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS- Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE- Patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctors, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS- The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT- Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I, _____, have read and understand the foregoing on _____.

Signature Date

Alliance Chiropractic and Massage
5720 Watauga Rd, Suite 100
Watauga, Texas 76148

Assignment of Benefits: Assignment of Cause and Action: Contractual Lien

The undersigned patient and/or responsible party, in consideration of treatment rendered or to be rendered or to be rendered and for deferred payment, irrevocably and exclusively assigns, grants and conveys, to SRB Wellness, Inc. DBA: Alliance Chiropractic and Massage, a lien and assignment of any other person and/or insurance company for reimbursement and/or payment of the medical charges incurred with all of the following right, power, and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment upon violation. I further instruct the provider to make all checks payable to SRB Wellness, Inc. DBA: Alliance Chiropractic and Massage.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to SRB Wellness, Inc. DBA: Alliance Chiropractic and Massage and to send any and all checks to 5720 Watauga Road, Suite 100 Watauga, Texas 76148.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by the caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted to me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

Signature of patient and/or Responsible Parties:

Signature: _____

Date: _____

*With my signature above, the full deductible or co-payment would be a financial hardship to me.