Health From Within
PATIENT CASE HISTORY

Name: ______________________________ Date of Birth: ___________ Social Security #: XXX-XX-_____

Address: _____________________________________City/State________________________Zip Code___________

Home Phone: ______-______-_______Work Phone: ______-______-_______ Cell Phone: ______-______-____________

Email Address: __________________________________ Occupation: __________________ Gender: ____________

Place of Employment: _____________________________ Insurer's Name: _________________________________

Emergency Contact ______________________________________ Emergency Phone Number _____ - _____- _______

Marital Status: S M D W Number of child(ren) and their age(s):_____________________________________

Minor (If under the age of 18, please complete this section)

Name of Parent or Guardian: ____

Address (if different than above):_______________________City/State____________________Zip Code___________

Phone: ______-______-_______

I, ______________________ give Dr. Schroeder permission to treat _______________________ without my presence.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ________________________________
and assign directly to Dr. Schroeder all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finically responsible for all chargers whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my heath care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X____Date ______________________

Medical Information

Date of last physical: ________________ Primary Care Physician: ____

List any doctors which you have seen in the past year and the reason(s) for the visit:

1.____

2.____

3.____

Have you had any auto or other accidents/traumas? ☐ No ☐Yes If yes, please provide details below.

Date: _________________ Describe: ____

Date: _________________ Describe: ____

Date: _________________ Describe: ____

Surgeries or Hospitalizations

Type / Reason	Year	Treatment required / Complications

Allergies

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen

☐ Seasonal Allergies ☐ Shellfish/Iodine ☐ Soaps ☐ Wheat ☐ X-Ray Dye ☐ Other: ________________________ Patient initials:_____

ALL Current and Past Medical History

☐ Ankle Pain ☐ Arm Pain ☐ Back Pain ☐ Elbow Pain ☐ Jaw Pain ☐ Knee Pain ☐ Leg Pain ☐ Shoulder Pain ☐ Hand Pain

☐ Foot Pain ☐ Hip Pain ☐ Mid-Back Pain ☐ Neck Pain ☐ Muscle Cramps ☐ Broken Bones ☐ Spinal Cord Injury

☐ Sprain/Strain ☐ Arthritis ☐ Joint Stiffness ☐ Genetic Spinal Condition ☐ Diabetes ☐ Polio ☐ Prostate Problems

☐ Eye/Vision Problems ☐ Hearing Problems ☐ HIV ☐ Hepatitis ☐ Cancer ☐ Depression ☐ Menstrual Problems

☐ Dizziness ☐ Epilepsy ☐ Fainting ☐ Fatigue ☐ Headaches ☐ Neurological Problems ☐ Parkinson's ☐ Multiple Sclerosis

☐ High Blood Pressure ☐ Chest Pain ☐ Stroke ☐ Heart Attack ☐ Minor Heart Problem ☐ Pacemaker ☐ Asthma

☐ Other: ____

____

Medications

Name	Date started	Reason taking	Side effects?

Supplements

Name	Reason taking	Name	Reason taking

Family History

M-Mother / F-Father / MGM-Maternal Grandfather / MGF- Maternal Grandmother /

PGF-Paternal Grandfather / PGM- Paternal Grandmother / B-Brother / S-Sister

____ Arthritis - Type(s):______________________ ____Cancer - Type(s):__________________________

____Depression/Anxiety ____Diabetes Type I or II ____Epilepsy/Seizures ____Stroke ____Asthma

____Neurological Problems ____Multiple Sclerosis ____Parkinson's ____Polio ____Back Pain

____High Blood Pressure ____Heart Problems ____Heart Attack ____Migraines ____Prostate Problems

____Genetic Spinal Condition

Other:____ Patient initials:_____

Doctor's Notes: ____

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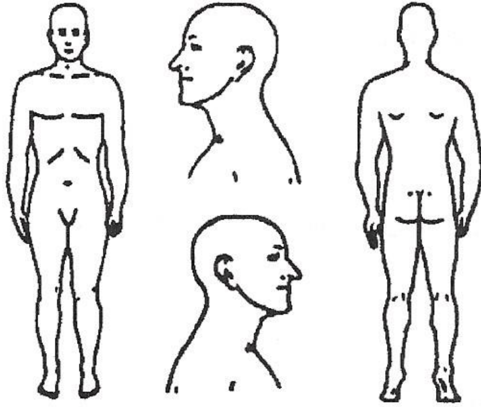
PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



What activities are affected by your current condition?

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Have you ever had chiropractic care? ☐No ☐Yes
When? __________ Why? __________
Where? ______________________
Were X-rays taken? ☐No ☐Yes
When was your last adjustment? __________

1. What is your **MAJOR** complaint? ______________________ Date problem began? __________

How did this problem begin (falling, lifting, etc.)? ______________________

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? ☐YES ☐NO

How often do you experience your symptoms? ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain
☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ______________________

Please rate your pain on a scale of 1-10 (0=no pain & 10=excruciating pain): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working, driving, self-care, exercise, etc.?
(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Which activities are restricted/painful? ______________________

What activities aggravate your condition (working, exercise, etc)? ______________________

What makes your pain better (ice, heat, massage, etc)? ______________________

2. What is your **SECOND** complaint? ______________________ Date problem began? __________

How did this problem begin (falling, lifting, etc.)? ______________________

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? ☐YES ☐NO

How often do you experience your symptoms? ☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Radiating Pain
☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: ______________________

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
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How do your symptoms affect your ability to perform daily activities such as working, driving, self-care, exercise, etc.?
(0= no effect and 10= no possible activities) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc)? ______________________

What makes your pain better (ice, heat, massage, etc)? ______________________

3. List any other complaints: ______________________

______________________ Patient initials:_____

Additional Health Analysis

Height: ___________ Present weight: ___________ Ideal weight: ___________ Weight 1 year ago: ___________

Maximum weight & when: _______________ Minimum weight as an adult & when: _________________

Do you smoke? ☐ No ☐ Yes If yes, how many per day? ________________

Do you drink alcohol? ☐ No ☐ Yes If yes, how many per day? ________________

Do you drink caffeine? ☐ No ☐ Yes If yes, how many per day? ________________ Coffee / Tea / Soda / Other:______

Do you exercise? ☐ No ☐ Yes If yes, what forms and how often? ______________________________________

How much water do you drink per day? ____

How many hours do you sleep per night? ______What time do you go to sleep? ____ Quality of sleep? ______________

Nightmares: Y N Wake refreshed: Y N Difficulty staying asleep: Y N Trouble Falling asleep: Y N

Sleep walk: Y N Grind teeth: Y N Must Nap During the Day: Y N Snore: Y N

Systems Analysis (mark all that apply)

Digestion – Bowel movements/day? ____ ☐IBS ☐Bloating ☐Gas ☐Constipation ☐Diarrhea ☐Nausea

☐Indigestion/Heart burn ☐Stomach Pain/Cramps ☐Hemorrhoids

Urinary – ☐Frequency (times/night? __) ☐Leak ☐Odor ☐Bedwetting ☐Weak flow ☐Kidney stones ☐UTI (past?)

Hormones – ☐PMS ☐Heavy flow ☐Cramping ☐Hot flashes ☐Low libido

Cardiac – ☐Palpitations ☐Varicose/Spider veins ☐Frequent signing/yawning ☐Irregular heart beat ☐Muscle cramps

☐Swollen ankles (ie: sock lines) ☐Bruise easily ☐Clots ☐Dizziness ☐Poor circulation

Brain – ☐Concussion (When? ______) ☐Headaches (How often? ______ / Location? ______) ☐Fog ☐Poor memory

Energy/Mood – ☐Anxiety ☐Depression ☐Fatigue (All day/Morning/Afternoon) ☐Irritable

Is there anything else you would like to share that has not yet been covered on this intake form?

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____

____

Patient signature:____ Date:______________________

Doctor's Notes: ____

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Patient Consent

Health From Within understands the need to reserve environmental resources. For this reason, we have decided to send statements electronically instead of utilizing many paper products, printer ink, environmental cost of deliver etc., thus decreasing our carbon footprint.

To start receiving your statements electronically, please read and sign the below consent form. We also require a secure e-mail that you check regularly. Please do not use a work e-mail address for these transactions. Employers may monitor these addresses thus having access to your personal information. For your discretion, no diagnosis will be given on these statements.

Consent to Receive Online Statements

I understand the risks of electronically transmitting personal information, including but not limited to: employers and online services having the right to inspect e-mail transmitted through their systems, e-mails not being secure and therefore breached by a third party, etc. Health From Within cannot guarantee, but will use reasonable means to maintain security and confidentiality of e-mail information sent and received. **No diagnosis or other information excluding services and charges will be provided on electronic statements. If you wish to know your diagnosis, please contact Health From Within.**

I understand I will receive electronic statements until I have provided written notice to Health From Within, *signed and dated, to cease the transmission of online statements and to receive hard copy statements.*

Please check **yes or no** if you would like to receive the following electronically:

I consent to receive **office information via e-mail** concerning changes in office hours and vacation days, upcoming events and specials, changes in regulations/fees, appointment reminders etc.

YES ☐ NO ☐

I consent to receive my **billing statement electronically** which I may pay by credit card, check or cash by either phone, mail or in person

YES ☐ NO ☐

I consent and request to receive **appointment reminders** from the following: (no additional charge)

TEXT ☐ E-MAIL ☐ BOTH ☐ NEITHER ☐

I consent to give Dr. Schroeder permission to take **pictures of my posture**- strictly for the purpose of tracking my progress. *These pictures will not be on display for ANYONE to see but you and the doctor*

YES ☐ NO ☐

Please print clearly

Patient Name (Please list all family members consent applies to): ____________________

Parent/Guardian Name (if under 18 years):____________________

Phone Number (if you wish to receive texts)____________________

Secure E-mail Address:____________________

Mailing Address: ____________________City:________State:______Zip Code:________

Signature:____________________ Date:____________

Patient Acknowledgement & Consent Form

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Health From Within or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

'I acknowledge that I am able to request a copy of the Notice of Patient Privacy Policy'

____

Patient Signature

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.
- You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

As our patient, we want you to know that we respect the privacy of your personal records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When appropriate, we provide the minimum necessary information to only those we feel are in need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest.

By my signature below I give my permission to use and disclose my health information.

____ ________________

Patient or Legally Authorized Individual Signature Date

____ ________________

Print Patient's Full Name

____ ________________

Witness Signature Date

INSURANCE FINANCIAL POLICY

Thank you for becoming a patient at our office. We are going to do our best to help you regain your health as quickly as possible. We would like to explain our office payment policy for those patients, like you, who are covered under private insurance.

1. We will call your insurance company to verify your coverage, deductible, and any other pertinent information. We will file your insurance claim for you at no charge. You are required to sign an "Authorization to Pay Physician" form and any other assignment documents required by your insurance company on your first office visit.

2. If your particular insurance plan requires a referral or pre-authorization, it is your responsibility to fulfill these obligations prior to your first visit or at the time of your first visit.

3. Our office cannot guarantee that your insurance will pay. We will make every attempt, at the beginning of your healthcare, to receive verification of your policy and what it covers. However, if your insurance claim is denied, or paid at a rate differently than quoted, you are responsible for the full amount of your bill.

4. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. Any balance not paid by your insurance company in 90 days will be billed directly to you and due upon request.

5. It is your responsibility to notify our office immediately if your insurance plan or coverage changes. Failure to do so may result in denial of your claim making the entire balance your responsibility.

6. If your policy has a deductible that has not been met or has been partially met for the current year, the outstanding deductible up to the cost of your initial office visit will need to be paid at the onset of care. (Arrangements for partial payments of large deductibles may be requested.)

7. If your deductible has been met, we will request payment of your percentage of your responsibility as you go along (i.e.: If your insurance pay 80% of your care, you will need to pay 20% on each visit or at the end of the week when multiple visits occur within a particular week.).

8. We will NOT bill secondary insurance, this is your responsibility.

If you have any questions, please feel free to ask. We'll be glad to help.

If you understand and agree with all of the above office policies, please sign your name below and we will accept your insurance assignment.

____

Printed name

____ ____________________

Patient signature Date

Cancellation Policy:

If you have an appointment that you are unable to keep, we require a *24 hour notice* so the time may be used to treat another patient. You are allowed one missed appointment before being charged. If you fail to show up without cancelling 24 hours prior to your appointed time, you will be charged the following:

Massage……… The FULL scheduled fee ($90/$50)

Nutrition…………………..... ½ the scheduled fee ($30)

Chiropractic………………………………….... $20 fee

Please initial to confirm you have read and understand the above information _______

Medicare ONLY: Non Covered items; Examination $20-$55, Therapies $5-$25, X-ray $45-$90, Supplements _______