

Case History

Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Birthdate _____ Age _____ SSN _____

Drivers Lic. # _____ Marital Status M S W D Sex M F

Were you referred? Y N By whom? _____ How did you hear about us? _____

Insurance being billed _____

Medicare PPO HMO Work. Comp. Personal Injury Cash Other

Relationship to insured Self Wife Husband Child Other

Employed Y N Employer _____ Years Employed _____

Address _____ City _____ State _____ Zip _____

Phone _____

Person to reach in case of emergency _____ Phone _____

Major Complaint _____

Duration of condition _____ Previous similar conditions _____

Activities that aggravate your condition _____

Condition is progressing: worse constant comes and goes

Condition interferes with work sleep Other: _____

How long has it been since you really felt good? _____

List surgical operations: _____

What medications are you taking? _____

Any other doctors seen for this condition? Y N Whom? _____

Diagnosis: _____ X-rays _____ Treatment _____

Results: _____

I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable. In the event of default I promise to pay interest on the indebtedness, together with reasonable attorney fees incurred by Ostir Chiropractic. In addition, up to 50% of the balance will added for collection costs as will be required to effect collection of this account. Please Initial _____

I have received and will read the new patient folder and understand that the employees are more than happy to address any questions or concerns. X-rays remain the property of this clinic.

Patient's Signature _____ Date _____

NAME _____ DATE _____ / _____ / _____
MONTH DAY YEAR

In the space below, please describe your major complaint.
If you have an additional complaint, please describe on page 3.

1. Please Describe Your Complaint: _____

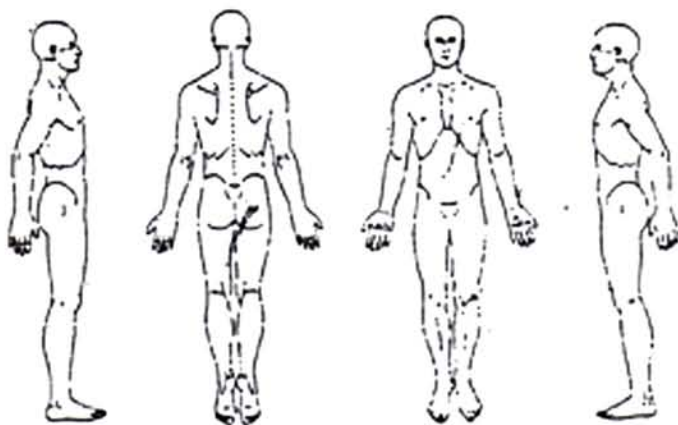
a. Description:

- Sharp Pain
 Dull Pain
 Ache
 Weak
 Throbbing
 Numb
 Shooting
 Gripping
 Burning
 Tingling

b. Frequency:

- Constant (76-100%)
 Frequent (51-75%)
 Occasional (26-50%)
 Intermittent (25% or less)

MARK ON THE PICTURE
WHERE YOU HAVE PAIN
OR OTHER SYMPTOMS.

c. Indicate intensity of your pain at its lowest and highest level No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Paind. Your symptoms are decreasing not changing increasinge. Symptoms are the worst in the Morning Afternoon Night Increases during the day Same all day

2. When did your problem begin: SPECIFIC DATE OF POSSIBLE? _____ Describe how your problem began: _____

3. Have you been treated for this episode? Yes NoIf yes, by whom? Chiropractor MD Osteopath Physical Therapist Occupational Therapist Other: _____Are you currently being seen? Yes No

When and what treatment? _____ / _____ / _____

4. In the past have you been treated for the same or similar problem? Yes NoIf yes, who did you see for that episode? Chiropractor MD Osteopath Physical Therapist Occupational Therapist Other: _____

When and what treatment did you receive? _____

5. What makes your problem better? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity6. What makes your problem worse? Nothing Lying down Walking Standing Sitting Movement/Exercise Inactivity7. How do you rate your general stress level? Little or No Stress Minimal Stress Moderate Stress Greatly Stressed8. General Physical Activity: No regular exercise program Light exercise program Moderate exercise program Strenuous exercise program

9. Are your complaints affecting your ability to be active?

- No Effect Some physical restrictions (able to perform light duty work and household tasks)
 Need limited assistance with common everyday tasks Need assistance often
 have a significant inability to function without assistance Am totally disabled (impaired). Cannot care for self

10. Physical activity at work: Sitting more than 50% of the day Light manual labor Manual Labor Heavy Manual Labor Repeated Motion1. Occupation: _____ FT PT Has work status changed because of this complaint? Yes No

2. What is your current work status?

- Full time, no restrictions Part time, with restrictions Unemployed Other: _____
 Full time, with restrictions Off work due to restrictions Retired
 part time, no restrictions Full time homemaker Full time student

Patient's Signature: _____ Date: _____ / _____ / _____

If you have ever had a listed condition in the past, please check it in the past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide concerning Past and Present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

| Past | Present | | Past | Present | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain (723.1) | <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm (441.5) |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain (719.41) | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure (401.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow (719.42) | <input type="checkbox"/> | <input type="checkbox"/> | Angina (413.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain (719.44) | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (410.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain (719.430) | <input type="checkbox"/> | <input type="checkbox"/> | Stroke (435) |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain (724.1) | <input type="checkbox"/> | <input type="checkbox"/> | Asthma (493.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain (724.2) | <input type="checkbox"/> | <input type="checkbox"/> | Cancer (199.1) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip (719.45) | <input type="checkbox"/> | <input type="checkbox"/> | Tumor (229.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee (729.5) | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems (601.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Ankle or Foot (719.47) | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder (790.6) |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain (526.9) | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) (492.8) |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness in Joint(s) | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (716.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting (780.2) | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis (714.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances (368.9) | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (250.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions (780.3) | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (349.5) |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness (780.2) | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer (556.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache (784.0) | <input type="checkbox"/> | <input type="checkbox"/> | Liver (573.9 / Gallbladder (575.9) problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination (781.3) | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones (592.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) (388.30) | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (573.3) |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat (785.0) | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection (595.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains (786.50) | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite (783.0) | <input type="checkbox"/> | <input type="checkbox"/> | Colitis (558.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia (307.1) | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon (564.1) |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight <input type="checkbox"/> Gain (783.1) <input type="checkbox"/> Loss (783.2) | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS (042) |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst (783.5) | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough (786.2) | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis (473.9) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue (780.7) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstrual Flow (626.4) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Proluse Menstrual Flow (626.7) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Soreness/Lumps (611.72) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis (617.9) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS (625.4) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control (788.30) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination (788.1) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination (788.41) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain (789.0) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/Irregular Bowel Habits (546.0) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing (787.2) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion (787.1) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash (692.9) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression (311) | | | |

If a family member has had any of the following please mark the appropriate box:

| | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Arthritis | <input type="checkbox"/> Chronic Back Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic Headaches |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Other Conditions _____ |
| <input type="checkbox"/> High Blood Pressure | |

| | | |
|------------------------------|-----------------------------|--|
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | Do you have a permanent disability rating? |
| <input type="checkbox"/> | <input type="checkbox"/> | Location _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Date rating received ____/____/____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rating Percentage _____% |

Please check any of the following that apply to you.

| Past | Present | | Past | Present | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy (V22.2) | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco (305.1) |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol (305.0) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hormonal/Estrogen Replacement | <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence (303.9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications (list if not listed elsewhere) | <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization/Surgical Procedures (list if not described elsewhere) | | | |

Present Weight _____ pounds Height _____ feet _____ inches

Patient's signature: _____ Date ____/____/____

Doctor's Additional Comments/General Health Concerns:

ASSIGNMENT OF BENEFITS FORM

Regarding: _____

Provider: Ostir Chiropractic Clinic, P.C.
1024 Essington Road
Joliet, IL 60435
(815) 729-2022

In consideration of your undertaking to treatment, I agree to the following:

RELEASE OF INFORMATION

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

RIGHT TO RECEIVE PAYMENT

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my Attorney out of the proceeds of any settlement of my case, or by any insurance company obligated to reimburse me for the charges for your services. I further authorize the endorsement of my name to any draft containing to which you are legally entitled. I understand that I am responsible for amounts not recovered.

ASSIGNMENT OF RIGHT TO SUE

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) shall be paid by me.
4. I give assignment and lien against claims against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.
5. I waive the Statute of Limitations regarding my doctor's right to recover.

Patient / Parent / Guardian

Date