Cook Chiropractic, Inc.
Case History

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Telephone ( )_____ Cell ( )_____ Email_____

Social Security No_____ Driver's Lic # _____ Birthdate_____

Age_____ Sex M F Marital Status M S W D No. Children_____ Occupation_____

Employer_____ Employer's Address_____

City_____ State_____ Zip_____ Telephone ( )_____

Spouse's Name_____ Occupation_____ Employer_____

Person responsible for this account_____ Address_____

City_____ State_____ Zip_____ Telephone ( )_____

Did someone refer you to our office? Y N Name _____ Telephone ( )_____

What is your major complaint? _____

Other Complaints? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? Y N

What is it about your condition that concerns you the most? _____

_____

Is your condition the result of an accident? Y N Describe_____

Is your condition the result of an auto accident? Y N If "Yes", complete the auto accident section of history form

Is your condition the result of an on the job accident? Y N If "Yes", complete the work comp section of history form

What activities aggravate your condition?_____

Is this condition getting progressively worse? Y N Are your symptoms Constant Comes and goes Staying the same

Is this condition interfering with your Work Sleep Daily Routine Other _____

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

List surgical procedures _____

Are you taking any medications? Y N What kind? _____

Any non prescription drugs? Y N What kind? _____

Have you seen other doctors for this condition? MD DC DO DDS

Doctor's Name _____ Address_____

City_____ State _____ Telephone ( )_____ Fax ( )_____

X-rays? Y N When?_____ Physiotherapy? Y N When?_____ How Many Sessions? _____

Results _____ Length of Time Under Care _____

Patient/ Legal Guardian Signature _____ Date_____

PERSONAL INJURY / AUTOMOBILE ACCIDENTS ( )Applies ( )Does Not Apply

Date of Accident_____ Time of Day_____ a.m. p.m.
Were you : ( )Driver ( )Passenger ( )Front Seat ( )Front Middle ( )Back Seat ( )Back Middle ( )Third Row
Number of people in your vehicle? _____ Were you wearing seat belts? ( )Y ( )N ( )Full belt ( )Lap only
In what town did the accident take place? _____State ____ Did airbag deploy ( )Y ( )N
What direction were you headed? ( )North ( )South ( )East ( )West
Name of street _____
What direction was the other vehicle headed? ( )North ( )South ( )East ( )West
Name of Street _____
Were you struck from ( )Front ( )Back ( )Driver's Side ( )Pass. Side ( )Front Panel ( )Back Panel ( )Bumper
Approximate speed of your vehicle _____ Other vehicle _____
Were ( ) police ( )State Trooper ( )none notified? Who was at fault (ticketed)? ( )You ( )Other ( )Your driver
Were you transported by an ambulance from the scene of the accident? ( )Yes ( )No If so, where were you taken? Name of facility_____Address_____City_____State_____
If you were not transported by an ambulance, where were you taken after the accident?_____
Have you been treated by any doctor since the accident ( )Yes ( )No
Name of Physician_____Address_____City_____State____Telephone_____
What treatment was given? Circle : Exam X-Rays CT Scan MRI Medication Surgery Sutures (stitches)
Physical Therapy Chiropractic care Other_____
Did you have complaints BEFORE THIS ACCIDENT? ( )Yes ( )No Describe_____
Do you have any birth problems that relate to this accident? ( )Yes ( )No Describe_____
Do you have previous illnesses that relate to this accident? ( )Yes ( )No Describe_____
How did you feel during the accident? _____
How did you feel immediately afterward?_____
How did you feel later that day?_____
How did you feel the next day?_____
Do you have any activity restrictions as a result of this injury? Describe_____
Have you lost time from work because of this accident? ( )Yes ( )No Last day worked_____Restricted Duties ( )Y ( )N

Type of Employment_____
Present Salary_____Are you being paid for lost work time? ( )Y ( )N Describe_____

Signature _____ Date_____

WORKER'S COMPENSATION ( )Applies ( )Does Not Apply

Date Injured_____Time_____( )am (pm) Last day worked_____ Are you off work? ( )Yes ( )No
Are you on restricted work duties? ( )Yes ( )No Describe_____
Previous Work Comp injury? ( )Yes ( )No Describe_____
Accident reported to ( )Safety Dept ( )Supervisor Name _____Telephone ( )_____
Witnesses? ( )Yes ( )No Name_____
What SPECIFIC injured body areas were originally reported and documented?_____
_____
Injured at: Address_____City_____State____Telephone ( )_____
Length of time worked there prior to accident_____
Type of work being done at the time of the injury_____
Have you been treated by any doctor since the accident? ( )Yes ( )No
Name of Physician_____Address_____City_____State____Telephone( )_____
What treatment was given? Circle: Exam X-Rays CT Scan MRI Medication Surgery Sutures (stitches)
Physical Therapy Chiropractic care Other_____
Are your symptoms: Constant Comes and goes Staying the same Getting worse
In a typical work day of _____hours, how many hours do you: Sit____ Stand____ Walk____ Bend____ Squat _____
Crawl_____ Climb_____Reach ____ Kneel_____ Climb_____ Push/Pull_____Other_____
List any additional comments:_____
_____
_____

Signature _____ Date_____

CHECK ALL THAT APPLY

HEAD

- ☐ Headache
  - o Sinus (allergy)
  - o Entire Head
  - o Back of Head
  - o Forehead
  - o Temples
  - o Migraine
- ☐ Head Feel Heavy
- ☐ Loss of Memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light Bothers Eyes
- ☐ Vision Problems
- ☐ Loss of Balance
- ☐ Dizziness
- ☐ Hearing Loss
- ☐ Pain/Ringing in Ears

NECK

- ☐ Pain in Neck
  - o Turn to Left
  - o Turn to Right
  - o Bending to Left
  - o Bending to Right
  - o Upward
  - o Downward
- ☐ Pinched Nerves
- ☐ Feels out of Place
- ☐ Muscle Spasms
- ☐ Grinding Sounds
- ☐ Arthritis

SHOULDERS

- ☐ Left
- ☐ Right
- ☐ Pain in the Joint
- ☐ Pain Across Shoulders
- ☐ Can't Raise Arm Above Shoulders
- ☐ Can't Raise Arm Over Head
- ☐ Muscle Spasms
- ☐ Arthritis
- ☐ Pinched Nerve

ARMS & HAND

- ☐ Left
- ☐ Right
- ☐ Pain
- ☐ Numbness
- ☐ Cold
- ☐ Burning
- ☐ Pins & Needles
- ☐ Upper Arm
- ☐ Forearm
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Fingers
- ☐ Arthritis
- ☐ Loss of Grip Strength

MID-BACK

- ☐ Pain
- ☐ Between Shoulder Blades
- ☐ Pain From Front to Back
- ☐ Spasms
- ☐ Pinched Nerve

CHEST

- ☐ Pain
- ☐ Shortness of Breath
- ☐ Pain in Ribs
- ☐ Breast
- ☐ Dimpled Breast
- ☐ Irregular Heartbeat

ABDOMEN

- ☐ Nervous Stomach
- ☐ Foods Can't Eat _____
  _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK

- ☐ Pain
- ☐ Stiffness
- ☐ Right
- ☐ Left
- ☐ Symptoms Worsen With
  - o Working
  - o Lifting
  - o Sitting
  - o Standing
  - o Bending
  - o Coughing
  - o Lying Down
  - o Walking
  - o Exercise
- ☐ Symptoms Better With
  - o Standing
  - o Sitting
  - o Lying Down
  - o Walking
  - o Exercise
- ☐ Unable to Straighten Back
- ☐ Difficulty Walking
- ☐ Slipped Disk
- ☐ Muscle Spasms
- ☐ Arthritis
- ☐ Sacroiliac

HIPS, LEGS, & FEET

- ☐ Left
- ☐ Right
- ☐ Pain
- ☐ Numbness
- ☐ Burning
- ☐ Tingling
- ☐ Upper Leg
- ☐ Lower Leg
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Cramps
- ☐ Pins & Needles
- ☐ Sharp Pain
- ☐ Weakness
- ☐ Swelling
- ☐ Cannot Stand Straight
- ☐ Cannot Sit Down
- ☐ Disrupts Sleeping
- ☐ Unable to Work
- ☐ Difficulty Walking

WOMEN ONLY

- ☐ Menstrual Pain
- ☐ Cramping
- ☐ Irregularity
- ☐ Birth Control_____type
- ☐ Hysterectomy
- ☐ Cancer
- ☐ Are You Pregnant?
- ☐ History of Cancer_____type

MEN ONLY

- ☐ Urinary Frequency
- ☐ Prostate Problems
- ☐ History of Cancer_____type

GENERAL

- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Sleep _____hours
- ☐ Cigarettes _____Pack/Day
- ☐ Alcohol _____Ounces/Day
- ☐ Caffeine (Coff., Tea, Red Bull, Monster, etc.)_____Oz/Day
- ☐ Diabetic _____Type
- ☐ High Blood Pressure

NOTES (For Doctor's Use Only)

COOK CHIROPRACTIC, INC.
Financial Policy

Thank you for choosing Cook Chiropractic, Inc. to provide your health care. We are committed to providing you the best possible healthcare. In order to prevent any misunderstandings, and to serve you better, we ask all patients/guarantors to read and understand our financial policy. We will gladly answer any questions you may have about services provided, fees, financial policy, or any other aspect of your care.

1. Payment is due at the time services are rendered
   - Forms of payment: cash, most credit and debit cards, and checks
   - Inability to make payment at the time of service may require your appointment to be rescheduled
   - Copays are collected at the time of check in
   - Deductibles, coinsurance and non-covered services must be paid at the time of service
2. Insurance acceptance and filing
   - As a courtesy, we will file insurance if it is one in which Cook Chiropractic, Inc. is contracted.
   - Changes in insurance should be provided prior to your visit. Present your new insurance card so we can verify that we are contracted with that plan.
   - If you do not inform us of a change, and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balances.
   - All charges are your responsibility regardless of insurance. Any amount due after insurance pays is your responsibility and due upon notification.
3. Medicare members
   - Since it can be considered Medicare fraud to waive deductibles and copays, you will be billed these amounts following Medicare reimbursement.
4. Forms and records
   - There will be a $35.00 charge to fill out/complete any forms that are brought into Cook Chiropractic, Inc. This fee will be collected prior to completion of forms.
5. Returned Checks
   - Returned checks will incur a $35.00 fee. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card to prevent further action.
   - Once there has been a returned check, we will no longer accept personal checks.
   - Unpaid checks are filed in court and you will be required to appear before a judge and pay court costs.
6. Accounts turned over to a collection agency
   - Accounts with no payment activity for 120 days may be turned over to collection.
   - Temporary financial problems may affect timely payment, so we encourage communication of such problems to us at 979-244-2900 so that your account can be properly managed.
7. Missed Appointments
   - Your appointments are booked at Cook Chiropractic Inc. according to your condition and needs. Failure to keep your scheduled appointments can result in a poor outcome of expected treatment results. Please notify the office 24 hours in advance if you cannot keep your appointment. We reserve the right to charge for missed appointments. Continued violation of this policy may result in dismissal from the clinic as poor treatment results are against the standards of Cook Chiropractic, Inc.

We are happy to help you maximize the allowable benefits with your health insurance plan. It is your responsibility to know and understand your own insurance benefits, coverage, pre-existing condition clauses, and referral/authorization requirements. We will assist when possible to help you in this often challenging endeavor. We look forward to serving your health care needs.

COOK CHIROPRACTIC, INC.

Confidential Patient Information

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

CONSENT TO TREATMENT

__I am the patient __I am the parent/legal guardian of the patient ___other_____

I hereby authorize such chiropractic care, treatment and diagnostic tests as may be recommended by Dr. Katherin Cook and/or associate doctors affiliated or employed by Cook Chiropractic, Inc. to ( )myself or ( )my minor child and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.

Name of Minor Child _____Age___ ( )Male ( )Female ( )Does not Apply

Signature _____ Date_____
Please check the appropriate box : ( )Patient ( )Parent ( )Legal Guardian

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE & FINANCIAL POLICY

__I am the patient __I am the parent/guardian of the patient __Other_____

I acknowledge that I have received the Office and Financial Policy for Cook Chiropractic, Inc. and agree to its terms.

Signature of Patient/Parent/Guardian_____ Date_____

AUTHORIZATION TO LEAVE RECORDED VOICE MESSAGES

__I am the patient __I am the parent/guardian of the patient __Other_____

I give my permission for Cook Chiropractic, Inc. physicians and staff to leave messages regarding office visits and appointments as well as any other health care information related to my treatment at the phone number(s) listed below:

Home_____ Work_____ Cell Phone_____

Signature of Patient/Parent/Guardian_____ Date_____

A photocopy or faxed copy of these authorizations shall be deemed as valid as the original_____

Cook Chiropractic, Inc. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulation, I hereby acknowledge that I have received a current copy of Cook Chiropractic, Inc.'s "NOTICE OF PRIVACY PRACTICES." Revision Date: _____

As required by the Privacy Regulations, _____ from
Name of Staff Member
Cook Chiropractic, Inc. has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Cook Chiropractic, Inc. has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Request:

[ ] I wish to file a "Request for Restriction" of my Protected Health Information.

[ ] I wish to file a "request for Alternative Communications" of my Protected Health Information.

[ ] I wish to object to the following in the "Notice of Privacy Practices":

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

_____ _____
Signature Date

_____
Print Name

_____

OFFICE USE ONLY

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe)

_____

_____

PARTIAL ASSIGNMENT OF THE CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN, AND AUTHORIZATION

(Agreement)

hereby direct any and all insurance carriers, attorneys, governmental agencies, companies, individuals, and/or other legal entities ›ayers),which may elect, or be obligated to pay proceeds to me for any reason, to pay directly to, and exclusively in the name of, Katherin ook DC/ Cook Chiropractic,Inc. , (or "Office") in the amount of the full charges incurred by me at the Office, past or future, including but ot limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("my harges"). I further grant a contractual lien to Katherin Cook, DC/Cook Chiropractic, Inc., with respect to my charges; however, I understand iat nothing in this Agreement shall be construed as an elect by Katherin Cook, DC/ Cook Chiropractic to claim protection under any tatutory lien law. For the purposes of this Agreement, proceeds shall include, but not be limited to, proceeds from any settlement, judgment, r verdict, as well asproceeds relating to the following insurance coverage: individual/group health, disability, worker's compensation, ıedical payments benefits, bodily injury, personal injury protection, lost wages, lost services, no-fault benefits, uninsured and underinsured ıotorist coverage, liability coverage, property damage coverage, and malpractice coverage.

further agree that, in the event a payer refuses to pay Katherin Cook, DC/ Cook Chiropractic, Inc., I hereby assign to the Office, insofar as ermitted by law, the following: all of my rights, remedies, and benefits to Katherin Cook DC/ Cook Chiropractic, Inc., as well as any and all auses of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my ame or in the Offices name, and the right to settle or otherwise resolve such causes of action as the Office sees fit.

n the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to Katherin ook, DC/ Cook Chiropractic, Inc. regarding my charges. Upon issuance, I agree that such letters) of protection cannot be revoked or nodified without the expressed written consent of the office. I further direct (and the Office hereby requests) each attorney to provide mmediate notice to the Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such unds, and to provide a full accounting of such funds to the Office upon its request.

hereby authorize and direct Katherin Cook DC/ Cook Chiropractic, Inc.to file my claim with my health insurance. I understand, however, hat in the event that my charges are submitted in their full amount to any other form of insurance or source of payment (e.g. liability, nedpay, attorneys, etc.), I hereby authorize and direct Katherin Cook DC/ Cook Chiropractic to collect any write-offs or discounts, issued by ny health insurance, out of the proceeds from the other insurance or source of payment.

hereby direct all payers to release to Katherin Cook DC/ Cook Chiropractic, Inc. any pertinent information regarding any coverage I may ıave including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I uthorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate ollection under this Agreement.

hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether ı claim has been established with said payers. I hereby authorize Katherin Cook DC/ Cook Chiropractice to endorse/sign my name on any nd all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse, or any of my lependents. I further authorize Katherin Cook DC/ Cook Chiropractic, Inc to apply any credit balances on charges incurred by me to any ›ther outstanding charges still owed by me, my spouse, and my dependents, regardless of whether these other charges are related to my ondition.

I understand that I remain personally responsible for the total amounts due Katherin Cook DC/ Cook Chiropractic, Inc for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments form me immediately upon endering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Katherin Cook DC/ Cook Chiropractic, Inc. for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of Katherin Cook DC/Cook Chiropractic, Inc. Specialty Group and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of Katherin Cook DC/ Cook Chiropractic, Inc. and myself. However, should any provision of this Agreement be found to be invalid, illegal, or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall,nevertheless, remain in full force and effect.

Patient Name (please print)_____

Patient Signature_____ Date:____/____/_____

Name of Custodial Parent of Legal Guardian (please print)_____

Parent Guardian Signature:_____ Date: ____/____/____

AMERICAN RADIOLOGICAL SERVICES

Cook Chiropractic, Inc. (419) 269-2140 (800) 442-1202

Patient: _____ Clinic: *Cook Chiropractic, Inc.* Film Date: _____

Age: _____ Sex [ ] Male [ ] Female Social Security #: ___/___/____ Date of Birth: _____

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

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Worker's Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provision, and I assign my insurance benefits as described above.

_____ _____

Signature Date

_____ _____

Witness Date

PATIENT HISTORY (OFFICE ONLY)

Patient Presentation _____

Trauma? [ ] Yes [ ] No If Yes, explain:

_____

_____

Malignancy? [ ] Yes [ ] No Details: _____

Diagnosis/Concerns/Questions (No ICD Codes, please) _____