

Melissa O'Loughlin, DC, CACCP
 23 Coach Street
 Canandaigua, N.Y. 14424



CONFIDENTIAL PATIENT CASE HISTORY

Date: _____

Dear Patient,

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Name	City	Social Security #
Address	State	Zip
Home Phone	Work Phone	Cell Phone
Age	Birth date	# Children
Marital Status (circle): M S W D	Occupation	
Spouse's Name	Spouse's Office/Cell Phone	
Referred by	Nearest Relative & Phone #	

HEALTH INFORMATION: Have you had previous chiropractic care? _____

What is your main complaint? _____

Other complaints: _____

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

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and goes

Is this condition interfering with your : Work Sleep Daily routine Other _____

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

Other doctors who have treated this condition _____

List surgical operations and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers "Pep" pills Insulin
 Tranquilizers Birth control pills Others _____

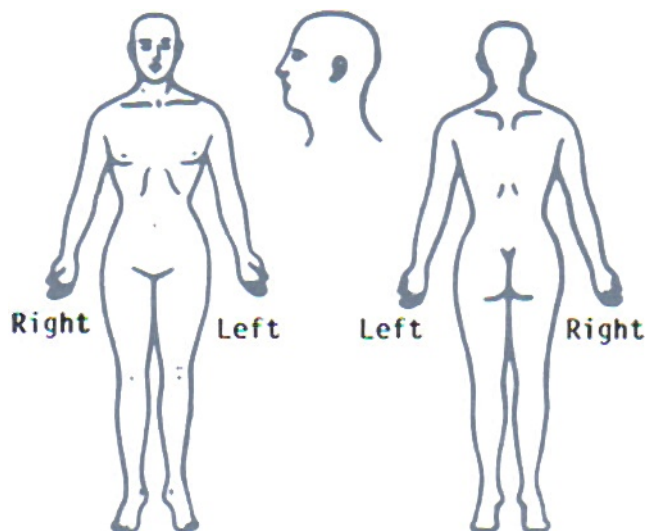
Age of mattress _____ Comfortable Uncomfortable

Are you wearing: Heel lifts Sole lifts Inner Soles Arch Supports

Have you been in an auto accident? Past year Past 5 years Over 5 years Never
 Describe: _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
 Describe: _____

Please mark your areas on the figures below



Have you Ever Suffered From:

1. Dizziness _____
2. Backaches _____
3. Heart Trouble _____
4. Diabetes _____
5. Arthritis _____
6. Headaches _____
7. Asthma _____
8. Neuritis _____
9. Digestive Disorders _____
10. Nervousness _____
11. Sinus Trouble _____
12. Neck Pain _____

Date of Last Physical Examination _____

FAMILY HEALTH INFORMATION: (Many health problems are the result of hereditary spinal weaknesses; thus the information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____ Yes _____ No
 Do you have Health Insurance? _____ Yes _____ No
 If yes: Name of Company _____ Policy # _____
 Are you covered by Medicare? _____ Yes _____ No
 If yes: Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account upon 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 will be paying today by _____ Cash _____ Check _____ Credit Card
 _____ Visa _____ MasterCard _____ Discover Account # _____ Exp. Date _____

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ S.S.#: _____

Dr. Melissa O'Loughlin
23 Coach St, Canandaigua, NY 14424

**PRIVACY ACT,
INFORMED CONSENT, & OFFICE POLICIES**

NOTICE OF PATIENT PRIVACY RIGHTS

By signing below, I acknowledge that I have received a copy of the "Notice of Privacy Practices" and a copy will be available for me at the reception desk upon my request. The Health Insurance Portability and Accountability Act ensures a patient's right to privacy regarding Personal Health Information and it is this office's policy to maintain confidentiality to the highest degree.

Patient/Legal Guardian's Initials: _____

INFORMED CONSENT

Any procedure intended to help may also do harm. While chiropractic examination and therapeutic procedures are usually considered remarkably safe and effective, please understand that occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is the practice of this chiropractic office to fully inform and educate all of our patients.

By signing below, I understand that these complications include, but are not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate or explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of my treatments which they feel at the time, based upon the facts then known, is in my best interests.

I understand that there is no guarantee or warranty for a specific cure or result. I understand that at any time, I can request further explanation regarding risks and benefits of care in this office, alternative courses of care, and the consequences of not having the proposed treatment.

Patient/Legal Guardian's Initials: _____

OFFICE POLICIES

I agree to take full financial responsibility for my care in the event that the assumed coverage (Worker's Compensation, No Fault Insurance, health insurance coverage, etc) is denied.

I further understand that the office charges a \$20 fee for returned checks. The office reserves the right to charge for appointments canceled without 24 hours notice and for not attending scheduled appointments.

I also understand that fee-for-service is required at the time of service or the office reserves the right to charge a \$5 fee.

Patient/Legal Guardian's Initials: _____

**I HAVE READ THIS FORM IN ITS ENTIRETY AND HAVE BEEN GIVEN THE
OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS.**

Patient/Legal Guardian Signature: _____

Print Name: _____ **Date:** _____

Doctor's Signature: _____

Date: _____

Thomas C. Wright, DC
Marcella M. Burkard, DC
Melissa S. O'Loughlin, DC
23 Coach St.
Canandaigua, NY 14424
(585) 394-2030

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under that Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

By signing below, I certify that I have received the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office, at any time, at the address above, to obtain a current copy.

Print Name: _____

Signature: _____

Signature of Legal Representative: _____
(Parent or Guardian if a minor)

Relationship to Patient: _____

Date Signed: _____