## Patient Health History

Today's Date / / Signature of Patient _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip Code _____

Primary Phone _____ Secondary Phone _____

Mobile Phone _____

Home email _____ Work Email _____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / Age _____ Gender *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other SSN _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or other Pacific Island
❑ Samoan ❑ Guamanian or Chamorro ❑ Other _____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Continued ...

# Cochran Chiropractic

Name_____ Date of Birth_____

Address_____ City, St, Zip_____

Home Phone_____ Cell Phone_____ SS#_____

Marital Status_____ Sex_____ Referring Person /Physician_____

## Employer Information

Employer/School_____ Work Phone_____

Employer Address_____ City, St, Zip_____

Parent/Spouse/Guardian_____

Parent/Spouse/Guardian Employer_____

Was this pain caused by a **work** related accident, if so when it occurred: _____

_____

Was this pain caused by an **Auto** related accident, if so when it occurred: _____

_____

Date of onset / Accident _____

## Medical History

Medical Problem Today_____

List any Drug Allergies (If any) _____

Family Physiaian_____

Please circle one of the following: Cash Insurance Workman's Comp Auto

**(Please give copies of all insurance cards you may have to receptionist)**

I authorize the performance upon myself/dependent, diagnostic, x-rays and physiotherapeutic procedures in the realm of chiropractic, for the state or Mississippi, to be performed by or under the direction of Dr. Joel H. Cochran. I acknowledge that no guarantee or assurance as to result that may be obtained from the procedures has been given by the above named doctor or his assistants.

**Blanket Authorizations and assignments:** I understand that the following authorization and assignments are to be used by Spine Care Network Chiropractic Services and all physicians associated therewith to effect the collection of benefits on my behalf. These authorizations and assignments become effective on the date of the first service rendered in my behalf and will continue in effect until the last date of service rendered on my behalf. Copies of the agreement will be as valid as the original. The instruction to you is an assignment of my rights under medical coverage to the extent of this bill.

**Blanket Authorization to release information:** I herby authorize Spine Care Network Chiropractic Services And all physicians associated herewith, to release information related to all treatment and care.

**Legal/ Collection fee:** I agree to pay all reasonable fees of attorneys and/ or collection agencies needed to affect collections of my delinquent charges outstanding on my account. I also agree that if at anytime there is need for legal action to be brought against any insurance company listed above, I will be responsible for instigating such action.

**Lien and Instructions to Council:** I give Dr. Joel H. Cochran a lien on my settlement, claim, judgment, verdict or result of said accident/injury/illness and I agree to irrevocably instruct my attorney to pay you in full from any proceeds of settlement, claims, or judgment related to this accident/injury/illness. I give Dr. Joel H. Cochran consent to treat my minor dependents/son/daughter.

_____ _____

**SIGNED PARENT/ INSURED/PATIENT** **DATE**

## QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

**Example:**

| | Headache | | | | Neck | | | | Low Back | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | (2) | 3 | 4 | (5) | 6 | 7 | (8) | 9 | 10 | worst possible pain |

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**1 – What is your pain RIGHT NOW?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible pain |

**2 – What is your TYPICAL or AVERAGE pain?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible pain |

**3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible pain |

**4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | worst possible pain |

**OTHER COMMENTS:**

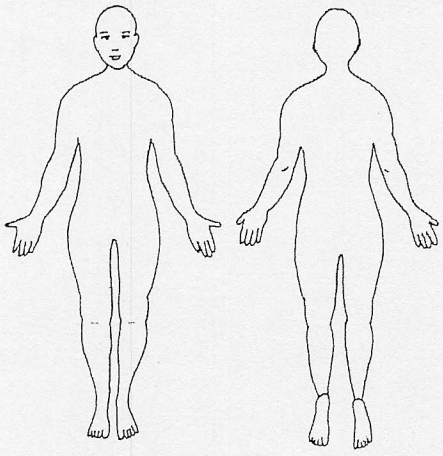
_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

1. Please shade in the area on the diagrams where your pain is located.



2. Please circle all that describe your pain:
   dull sharp throbbing burning deep aching tingling stabbing cramping numbness radiating

3. How often during the day do you feel your pain? (Circle one)
   10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100% of the day

4. When is your pain worse? (Circle one) morning afternoon evening night unchanged

5. Does pain radiate to arm? (Yes No) Which Side? (Left Right Both)

   How far down? (To elbow wrist hand/fingers other [Please Explain])

   Does pain radiate to legs? (Yes No) Which Side? (Left Right Both)

   How far down? (To buttock knee ankle foot/toes other [Please Explain])

6. Please circle all that aggravate your pain: sitting standing walking bending stooping lifting sleeping sneezing coughing straining reaching twisting looking up looking down movement rest lying on your back driving typing scooping house chores exercise lying on your stomach stair stepping

7. Please circle all that decrease your pain: sitting standing lying knees bent up support no movement movement heat ice topical analgesic ibuprofen medication rest stretching/exercise adjustments massage

*Please list all treatments you may have had in relation with **THIS PAIN PROBLEM.***
*Include the dates of the procedure and the results*:

| **TREATMENTS** | **PAIN RELIEF** | **DATE DONE** |
|---|---|---|
| _____ | **YES or NO** | _____ |
| _____ | **YES or NO** | _____ |
| _____ | **YES or NO** | _____ |
| _____ | **YES or NO** | _____ |
| _____ | **YES or NO** | _____ |

**NOTE:**

_____
_____
_____

*Please indicate which diagnostic procedures (test) you have had for **THIS PROBLEM.***

| **PROCEDURES:** | | **DATE:** |
|---|---|---|
| CT- SCAN | **YES or NO** | _____ |
| EMG | **YES or NO** | _____ |
| MRI- SCAN | **YES or NO** | _____ |
| MYELOGRAM | **YES or NO** | _____ |
| X-RAY | **YES or NO** | _____ |

*Please list any allergies you may have to medications.*

a._____ b._____ c._____

*Please list all medications (prescription and none -prescription) that you are currently taking.*

_____

_____

***PAST MEDICAL HISTORY:*** *Circle condition you have or have had in the past.*

**Alcoholism**
**Anemia**
**Arthritis**
**Asthma**
**Bleeding disorder**
**Cancer**
**Chemical dependency**
**Chicken pox**
**Diabetes**
**Emphysema**
**Glaucoma**
**Gout**
**Heart disease**
**Hepatitis**
**HIV positive**
**Hypertension**
**Kidney disease**
**Liver disease**
**Migraine headaches**
**Mononucleosis**
**Multiple sclerosis**
**Mumps**
**Pacemaker**
**Polio**
**Psychiatric care**
**Rheumatic fever**
**Seizures**
**Shingles**
**Stroke**
**Suicide attempt**
**Thyroid problems**
**Tuberculosis**
**Ulcers**
**Vascular disease**
**OTHER PLEASE LIST:**

*Please list all surgeries you have had, approximate dates, and surgeon's name:*

*Please circle the symptoms you currently have or had in the past year:*

**CARDIOVASCULAR**
Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling of ankles

**EAR, NOSE, THROAT**
Bleeding gums
Difficulty swallowing
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent coughs
Ringing in ear
Sinus problems

**NEUROLOGICAL**
Blackouts
Headaches
Migraines
Seizure
Sensory loss
Stroke
Weakness

**EYES**
Blurred vision
Double vision
Vision-flashes
Vision-halos

**GASTROINTESTINAL**
Appetite poor
Bloating
Bowl changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

**RESIRATORY**
Cough
Cold
Shortness of breath
Wheezing

**GENERAL**
Chills
Depression
Dizziness
fainting
Fever
Forgetfulness
Loss of sleep
Loss of weight
Nervousness
Sweats

**MUSCLE/JOINT/BONE PROBLEMS**
Arms
Back
Feet
Hands
Hips
Legs
Neck
Shoulders

**SKIN**
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

*Please circle if your blood relatives had any of the following:*

Arthritis
Asthma
Cancer
Chemical dependency
Diabetes
Heart disease
Strokes
High blood pressure
Kidney Disease
Tuberculosis
Low back pain
Other:

How many hours do you sleep at night? _____

Do you Smoke? _____ if so how many per day? _____

How much coffee or caffeinated beverages do you drink daily? _____

How much beer or alcoholic beverages do you drink on a daily basis? _____

Do you exercise on a daily basis? _____

What is your occupation? _____

# Release of Information

I, _____, hereby authorize the doctors, therapist, and staff of Spine Care Network, Chiropractic Services, to give the following people information concerning my health and well being.

_____ Spouse Name:_____

_____ Significant Other Name:_____

_____ Other Person(s) Name:_____

Name:_____

Name:_____

Name:_____

The following information may be given to the above individuals:

_____ Appointment Time _____ Test/Lab Results

_____ Procedures _____ Billing/Finance Information

_____ Any other information regarding my health

I also authorize Spine Care Network, Chiropractic Services to leave a message on my answering machine, voice mail, or with someone at my residence regarding upcoming appointments, missed, or rescheduled appointments.

_____ Yes _____ No

I understand I may revoke this consent at any time by giving written notice to Spine Care Network, Chiropractic Services making this disclosure.

Signed: _ _____ Date:_____

Witness: _____ Date:_____

## *Acknowledgement of Receipt: Notice of Privacy Practice*

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practice" from the staff at Spine Care Network, Chiropractic Services upon my first visit. A list of potential disclosures, my rights as a patient, and a complaint process is included. I understand that any questions that I may have can be answered by Spine Care Network, Chripractic Services's Privacy Officer or acting Office Manager.

Signed:_____

Date:_____

Witness:_____

# Cochran Chiropractic

*Joel H. Cochran, D.C.*
*National Board Certified Chiropractic Physician*
*4 Doctors Drive, Suite A, Ocean Springs, MS 39564*

## Our Financial Policy

Thank you for choosing Cochran Chiropractic for your chiropractic care. We are committed to providing you with the best possible care and your clear understanding of our financial policy is important to our professional relationship.

**General Office Rules:** We believe that your time is as valuable as ours. We do not overbook patients except in case of an emergency and we do our best to stay on schedule to avoid any delays to you. If you arrive late you may be asked to sit and wait or be asked to reschedule your appointment for a later time. We are required to keep patient demographic information as up to date as possible and are required to get a copy of your insurance card(s) and driver's license. Please understand that we may ask if any changes have occurred with your insurance, address or phone numbers. On occasion you may receive a reminder call, however, please realize it is each individual's responsibility to keep track of appointment made. If you need to cancel or reschedule an appointment, please give us notice so that we may schedule another patient in the slot reserved for you.

_____ If you fail to cancel your muscle therapy appointment no less than 24 hours in advance, a $30 fee
Initial will be charged to your account and is payable prior to future visits.

_____ Any returned checks will be subject to a $30 service fee. Any returned check must be resolved
Initial before any future appointments will be arranged.

_____ Payment for Co-pays, Deductibles or any procedure not covered by insurance will be collected
Initial before you are seen for your appointment.

_____**Insurance:** As a courtesy to you, we bill your insurance company and will assist you in receiving maximum benefits. Insurance is a contract between you and your insurance company. We are not a party of this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, ect. If your insurance company mails you a check, please contact us ***immediately***, as this may be payment for services rendered. If your insurance company has not paid the **Full Balance** within 60 days, you will be responsible for payment of the balance. We realize that temporary financial problems may affect timely payment for your account. If such problems do arise, it is recommended that you contact our billing department so that a payment plan can be initiated to avoid your account being turned over to collections. If your account is sent to collections, the collection service cost will also be your responsibility. **It is the ultimate responsibility of the patient to understand his/her coverage and to find out whether our providers are in your network. Insurance polices may change and/or insurance company representatives may not always give us correct or consistent information. In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered. If you have an outstanding balance with Cochran Chiropractic you will be required to make monthly payments on this balance. Our billing Department will be glad to assist you in these matters.**

_____**Medicare/Medicaid:** We accept Medicare/Medicaid for spinal manipulations. However, under the plan guidelines, some chiropractic services are not covered (See ABN Form) and the patient will be responsible for those charges if rendered..

_____**Cash:** Payment is due when services are rendered for all cash patients.

We thank you for understanding our financial policies. This has become necessary in order to continue to accept insurance plans and avoid patients paying for their care and await reimbursement from their insurance company. Our goal is to make your visit with us pleasant and professional. If you have any questions please feel free to contact our billing department for assistance.

**Provider and patient agree that this financial policy is necessary for us to continue to provide your medical services. Failure of the patient to abide by the terms of this financial policy may result in termination of your care by the Provider at Cochran Chiropractic.**

This Agreement was entered into on this_____ day of _____20____.

Patient Witness

I acknowledge receipt of a copy of this Agreement on the date stated above_____
Initial

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

☐ What is the name of your favorite pet? ☐ In what city were you born? ☐ What high school did you attend?
☐ What is your favorite movie? ☐ What is your mother's maiden name? ☐ On what street did you grow up?
☐ What was the make of your first car? ☐ When is your anniversary? ☐ What is your favorite color?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

*If yes, how often do you smoke:* ☐ Current every day smoker ☐ Current sometimes smoker

*If yes, what is your level of interest in quitting smoking?*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

*No interest* *Very Interested*

Current medications, including dosage if known.
If there are no current medications, check here: ☐

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any known allergies you have had to any medications.
If no allergies are known, check here: ☐

1) _____ 3) _____

2) _____ 4) _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension presently? ☐ Yes ☐ No If yes, describe: _____

_____

Has any doctor diagnosed you with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II

*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?* ☐ Yes ☐ No ☐ Not Sure

*If yes, other comments regarding Diabetes:* _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ Yes ☐ No

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____ / _____