Beauty and Bones
THE DR. SCOTT CHIROPRACTIC, LLC
95 S. Liberty St.
POWELL, OH 43065

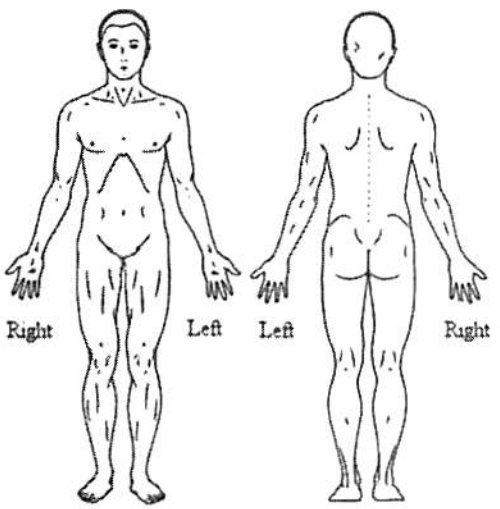
CASE HISTORY

Name _____ Age _____ Date _____
Address _____ City _____ State_____ Zip_____
Phone (cell) _____ Date of Birth _____ Sex: M F Marital Status: S M D W
Occupation Employer _____ Phone (Work)_____
Insurance Company_____ Email_____
Spouse's Name _____ Spouse's Occupation _____
Spouse's Employer _____ Spouse's Phone (cell)_____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

HEALTH REPORT:

Reason for seeking care: _____
List any other doctors seen for this: _____
List any type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
Have you received chiropractic treatment previously? __ Yes __ No
If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
Are you currently taking medication? __ Yes __ No list medications: _____
_____
List conditions you are taking medications for: _____
List the approximate dates of any surgery or treated conditions:_____
Family History: Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____

Do you smoke Y/N ____ ☐Alcohol Y/N __Daily __Weekly __Social Occasions ☐Caffeinated drinks per day ____ Do you take Vitamins/Supplements Y/N If yes, type and how often _____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness = = =
Dull Ache OOO

Burning XXX
Sharp/Stabbing / / /
Pins, Needles + + +
Other _____ ^ ^ ^

What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?_____
Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain b/n Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy

FOR WOMEN ONLY
__ Birth Control
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient

Signature_____Date_____

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge. I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period_____.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship or authority if not signed By patient

_____

Witness

The Dr. Scott Chiropractic
95 S. Liberty St.
Powell, OH 43065

A Special Message from Dr. Scott Shearer, Clinic Director

Dear Patient,

Welcome to the office! We are honored you have chosen this office to provide Chiropractic care to you and/or your family. Be assured that we will do everything in our power to give you a very positive experience. Our aim is to get you well and help you meet your health goals...period. Our office mission and guarantee:

"If we can help you, we will tell you. If we cannot help you, we will tell you that as well and make the proper referral. "

Notice of Privacy Practices

In accordance with the Protected Health Information Act (PHI) our office will, without asking your express consent or authorization, use and disclose your PHI for the purposes of:

o Treatment
o Payment
o Health Care Options
o Advice of Appointments and Services
o Directory/Sign-In Log
o Court Orders, Subpoenas and Government Investigations
o Advise Family/Friends directed by you to receive information regarding your health or to assist in the payment of your bill.

You have the right to revoke, request special limits or conditions, to receive communication by more confidential means or at alternate locations, to inspect and copy your PHI, and to amend your PHI.

Copies of the NPP may be obtained upon request. Our office strives to maintain HIPAA compliance.

I understand that by signing the above statement I have been notified of my rights in compliance with HIPPA regulations. I have been advised that I may request a complete copy of these rights available through the HIPAA officer at this location.

_____ Signature

_____ Date

If you ever need anything, just ask one of our staff or call me directly at 614-218-0788. I'd love your feedback on how we are doing in terms of meeting, hopefully exceeding your expectations so that you will refer your friends, family, and co-workers. The greatest compliment we can receive is the trust placed in us via your referrals. We value that trust! Again, welcome to the office.