CASE HISTORY

Date _____ Case No. _____

Name _____ Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Sex M F Marital Status S M D W Email _____

Occupation _____ Employer _____ No. of Children _____

Referred by _____ Past Chiropractic Care Yes _____ No _____

When _____ Dr.'s Name _____ Results _____

Chief Complaint _____

Insurance Co. _____ Social Security No. _____

Are your present injuries due to on-the-job injury? Yes _____ No _____

Have you made a report of your accident to your employer? Yes _____ No _____

Do you plan on turning it in to workman's compensation? Yes _____ No _____

Are you now or have you ever been disabled (service or work)? Yes _____ No _____.

Name of Spouse _____ Spouse Employed by _____

****

Please check all of the following symptoms and signs which you now have or have had within the last 6 months. An understanding of your health status will facilitate care.

GENERAL SYMPTOMS

_____ Headache
_____ Fever
_____ Chills
_____ Night sweats
_____ Fainting
_____ Dizziness
_____ Convulsions
_____ Loss of sleep
_____ Fatigue
_____ Nervousness
_____ Loss of weight
_____ Numbness or pain in arms, legs, hands,
_____ Allergy (what)
_____ Wheezing
_____ Neuralgia

MUSCLE & JOINTS

_____ Weakness
_____ Twitching
_____ Stiff neck
_____ Backache
_____ Swollen joints
_____ Tremors
_____ Foot trouble
_____ Painful tail bone
_____ Pain between shoulders
_____ Hernia
_____ Spinal curvature
_____ Growing pains
_____ Faulty posture

GASTRO-INTESTINAL

_____ Poor appetite
_____ Poor digestion
_____ Excessive hunger
_____ Belching or gas
_____ Nausea
_____ Vomiting
_____ Vomiting blood
_____ Pain over stomach
_____ Constipation
_____ Diarrhea
_____ Colon trouble
_____ Hemorrhoids (piles)
_____ Liver trouble
_____ Jaundice
_____ Gall Bladder trouble

CARDIO-VASCULAR

_____ Rapid heart
_____ Slow heart
_____ High blood pressure
_____ Low blood pressure
_____ Pain over heart
_____ Previous heart trouble
_____ Swelling of ankles
_____ Poor circulation
_____ Varicose veins
_____ Strokes

EYE EAR NOSE THROAT

_____ Poor vision
_____ Crossed eyes
_____ Pain in eyes
_____ Deafness
_____ Earache
_____ Ear noises
_____ Ear discharge
_____ Nasal obstruction
_____ Nose bleeds
_____ Sore throat
_____ Hoarseness
_____ Hay fever
_____ Asthma
_____ Frequent colds
_____ Enlarged thyroid
_____ Tonsillitis
_____ Sinus trouble

SKIN

_____ Skin eruptions
_____ Itching
_____ Bruising
_____ Dryness
_____ Boils
_____ Sensitive skin
_____ Hives or allergy
_____ Eczema

RESPIRATORY

_____ Chronic cough
_____ Spitting blood
_____ Spitting phlegm
_____ Chest pain
_____ Difficulty breathing

GENITO-URINARY

_____ Frequent urination
_____ Painful urination
_____ Blood in urine
_____ Kidney infection
_____ Bed wetting
_____ Inability to control urine
_____ Prostate trouble

FOR WOMEN ONLY

_____ Painful periods
_____ Excessive flow
_____ Irregular cycles
_____ Hot flashes
_____ Cramps or backache
_____ Miscarriage
_____ Vaginal discharge
_____ Pregnant at this time

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES?

_____ Polio
_____ Anemia
_____ Measles
_____ Mumps
_____ Cancer
_____ Goiter
_____ Flu
_____ Chorea
_____ Lumbago
_____ Eczema
_____ Sciatica
_____ Epilepsy
_____ Diabetes
_____ Pleurisy
_____ Malaria
_____ Small Pox
_____ Appendicitis
_____ Alcoholism
_____ Tuberculosis
_____ Chickenpox
_____ Pneumonia
_____ Rheumatism
_____ Diphtheria
_____ Arthritis
_____ Heart disease
_____ Scarlet fever
_____ Typhoid fever
_____ Rheumatic fever
_____ Venereal infection
_____ Mental disorders
_____ Whooping cough

OPERATIONS

Date_____ Tonsilectomy Date_____ Appendectomy Date_____ Hernia

Date_____ Gall Bladder Date_____ Female Organs Date_____ Thyroid

Date_____ Back Operations Date_____ Rectal Surgery

Other_____ (list type and date)

Date of accident/illness_____ Hour_____ AM_____ Location: _____

How did accident occur? ☐Auto Collision ☐On-the-job ☐Other _____

Please describe the circumstances _____

BROKEN BONES OR DISLOCATIONS: _____

_____

Have you ever had any spinal taps or spinal injections? Yes _____ No _____

Were you ever knocked unconscious? Yes _____ No _____

Have you ever had a lapse of memory? _____ Have you ever had X-Ray pictures made of your case? _____

If so, by whom? _____

For what ailments were these pictures made? _____

Do you suffer from any condition other than that which you are now consulting us? _____

_____

Are you presently taking any medication - Prescription or Patent? _____

If so, what drugs? _____

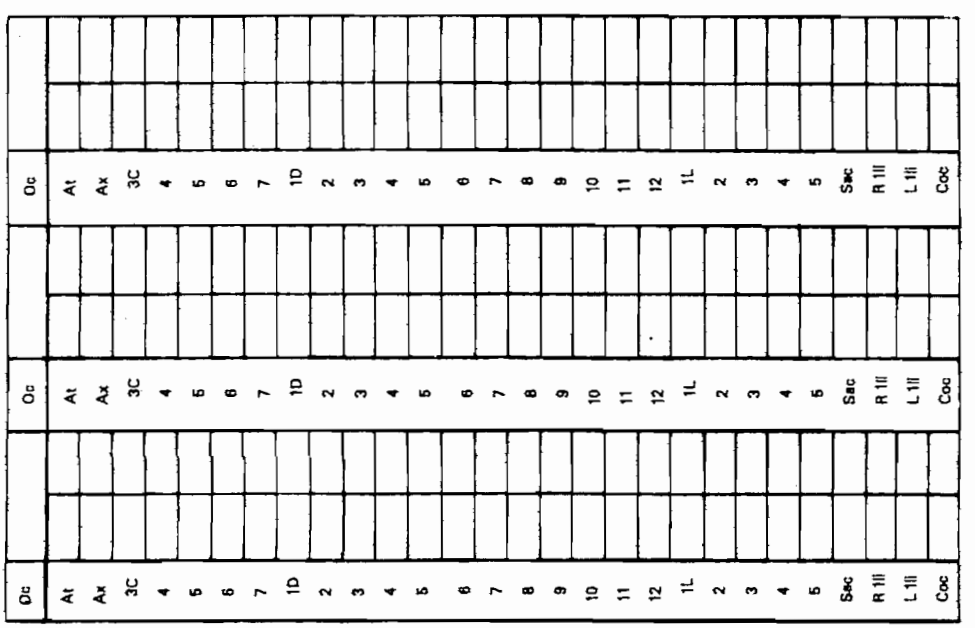
NOTE: It is understood and agreed the amount paid the Basler Chiropractic Center for X-Rays, is for examination only and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

Signature: _____ Date: _____

To avoid added bookkeeping expense, payment is expected at the time service is rendered unless other arrangements are made.

BOTTOM OFFICE USE ONLY

SPINAL EXAMINATION & ANALYSIS



VISUAL POSTURE ANALYSIS A-P

Head Tilt RT LT R. Ear Hi Lo

R. Shoulder Hi Lo Scapula H L

R. Ilium Hi Lo LAT:

Head Carried _____

Cervical Spine _____ Curve

Dorsal Spine _____ Curve

Lumbar Spine _____ Curve

Areas of Muscle UNDERDEVELOPMENT

	LEFT	RIGHT
Laseque		
Braggard		
Faber		
Shoulder Depressor		
Foramina Compression		
Leg Raiser		
Ely		
Trendelenburg		
Derafield		

X-Ray Views _____

Abnormalities _____

Adjustment Schedule _____

Basler Chiropractic Center

DR. CLAUDE J. BASLER, DIRECTOR

351 WEST MAIN - IONIA, MICHIGAN 48846
PHONE (616) 527-6300
FAX (616) 527-0038
EMAIL baslerchiro@gmail.com

PATIENT NAME _____

PATIENT ADDRESS _____

ASSIGNMENT OF PAYMENT

I hereby authorize my attorney and/or insurance company to pay directly to Dr. Claude J. Basler any monies due him for services which would otherwise be payable to me.

Further, I agree to pay Dr. Claude J. Basler the difference, if any, between the amount of his charges and the amount paid him by my attorney and/or insurance company.

_____

Signature of patient or insured Date

* * * * * * * * * * * * * * * * * * *

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Claude J. Basler to release, as he deems necessary, any and all information acquired in the course of my examination and/or treatment.

_____

Signature of patient or insured Date

Basler Chiropractic Center

DR. CLAUDE J. BASLER, DIRECTOR

351 WEST MAIN - IONIA, MICHIGAN 48846
PHONE (616) 527-6300
FAX (616) 527-0038
EMAIL baslerchiro@gmail.com

Welcome and thank you for your display of confidence in our office. We are committed to providing you with the best possible care. We would like to take this opportunity to explain our office policies to you. Please keep a copy of this letter for future reference.

Insurance Plans: We bill BC/BS, Medicare, and most third party insurances. **Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is impossible for us to know the details of your contract. Not all services are covered benefits in all contracts. You will be responsible for services that your insurance carrier does not pay.**

Co-payments: Your co-payments and deductibles are your responsibility and are due at the time of service. We accept personal checks, cash, Mastercard, Visa and Discover.

Referrals/Authorizations: If you have an insurance that requires a referral, **you are responsible for providing written authorization from your primary care physician and/or your insurance company. Authorizations must be presented at the time of service. Unauthorized services are your financial responsibility.**

If you have any questions, please feel free to ask.

PATIENT SIGNATURE _____

Basler Chiropractic Center

DR. CLAUDE J. BASLER, DIRECTOR

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PHONE (616) 527-6300
FAX (616) 527-0038
EMAIL baslerchiro@gmail.com

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Dr. Basler's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Dr. Basler's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Basler. The Notice of Privacy Practices for Dr. Basler is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my right and Dr. Basler's duties with respect to my protected health information.

Dr. Basler reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Dr. Basler's website (if applicable).

I have the right to revoke this consent, in writing, except to the extent that Dr. Basler has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

INFORMED CONSENT TO CHIROPRACTIC CARE

BASLER CHIROPRACTIC CENTER
Dr. Claude J. Basler, D.C.
351 W Main St., Ionia, MI 48846 • 616-527-6300

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of rehabilitative exercises, on me (or on the patient below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are risks to treatment. Risks include, but are not limited to, bruises, fractures, disc injuries, strokes, dislocations, and sprains. Treatment may create pain or defer pain to other locations.

I understand that I may be receiving the following treatment:

1. Physical Exam
2. Spinal Manipulation
3. A.R.T. (Active Release Technique)
4. Referrals for other treatment

I understand my health insurance (if any) may or may not cover charges for all treatment(s) received, and I am responsible for the payment of these charges.

I understand that after two years of not receiving treatment in this office I am considered a new patient, which will require the doctor to complete a new patient physical exam again.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient_____ Date_____

Signature of Parent/Guardian_____ Date_____

Witness Signature_____ Date_____

Doctor's Signature_____ Date_____

Medicare One-Time Authorization

I request payment of authorized Medicare benefits to be made either to me or on my behalf to Basler Chiropractic Center, for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient_____ Date_____

□ Completed □ DXs entered File # _____

EHR History & Examination

Patient Name_____ Date _____

1. *Demographics*

Don't know/ prefer not to say □

A. Ethnicity □ non-Hispanic □ Hispanic

□ B. Preferred language □ English □ Spanish □ other _____

□ C. Race □ white/Caucasian □ African American □ native American □ Hawaiian/Pacific Isl □ other _____

2. *Would you like an e-mail reminder of upcoming appointments?*

□ *YES □ NO email _____

*_____ *(please initial)* ***I hereby give my consent to have my health records available to me via a secure, web-based portal.***

3. *Are you taking any medications?* □ YES □ NO

If yes, please list medications (be specific) you are currently taking along with dosage. *If you have a med list, we can copy it for you instead.

_____ _____

_____ _____

_____ _____

4. *Are you allergic to any Medications?* □ YES □ NO

If yes, please list medications you are allergic to and the problem experienced:

_____ _____

_____ _____

5. *Do you smoke now?* □ YES □ NO

Have you ever been a smoker? □ YES □ NO

Do you use any other form of Tobacco? □ YES □ NO

If a current tobacco user, please complete the following:

What type _____

How much _____

Have you tried to quit? □ YES □ NO

What methods did you use _____

DOCTOR ONLY

***Vital Signs** height _____ weight _____ BP ____/____ Pulse _____