RODERICK WHITE CHIROPRACTIC

2101 Magnolia Avenue S.
Magnolia Building # 411
Birmingham, AL 35205
P (205) 847-1633

1960 Chandalar Drive
Suite E
Pelham, AL 35124
P (205) 664-8881

Fax (844) 965-9141

Chiropractic Case History/Patient Information

First Name:________________ MI:_____ Last Name:__________________ DOB:__________

Address:______________________________City:______________ State:_____ Zip:________

E-mail Address (we **only** use your e-mail address for appointment reminders and office communications):

____

Cell Phone:__________________________ Home Phone:__________________________

Best number to reach you regarding appointments: ☐ Home ☐ Cell ☐ Work

Age:______ Race:______ Marital Status: M S W D Social Security #:__________________

Occupation:____________________ Employer:__________________________________

Employer's Address:__________________________ Work Phone:____________________

Spouse:______________ Occupation:______________ Employer:____________________

Names and Ages of Children:____

Name of Nearest Relative:__________________ Address:______________Phone:________

How did you find out about our office?____

Family Medical Doctor:____

May we have your permission to update your medical doctor regarding your care at this office?________

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company:____

Policy Holder:__________________________ Relationship to Patient:________________

Policy Holder's DOB:____________________ SS#:___________________________________

Name of Secondary Insurance Company (if any):__________________________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

____

Patient's Signature:______________________________________ Date:______________

Guardian's Signature Authorizing Care:______________________ Date:______________

Authorizations, Releases and Acknowledgements

HIPAA/Notice of Privacy Policy Acknowledgement
I have received, read and understand the "Notice of Privacy Practices" containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the "Notice of Privacy Practices" from time to time, and that I may contact Dr. Roderick White / Roderick White Chiropractic to obtain a copy of the "Notice of Privacy Practices" at any time.

_______ Initials

Consent for treatment:
I, the undersigned patient, consent to and authorize the performance of any diagnostic exam(s) and the treatment as deemed necessary by Dr. Roderick White.

_______ Initials

Consent for the treatment of a minor:
Anyone under the age of 18 will not be treated without a parent or legal guardian present, unless the patient is an emancipated minor. I, the parent or legal guardian of the patient, consent to and authorize the performance of any diagnostic exam(s) and the treatment as deemed necessary by my physician(s) at Dr. Roderick White / Roderick White Chiropractic.

_______ Initials

Pregnancy Disclosure:
I acknowledge that I am not pregnant and authorize Dr. Roderick White to perform diagnostic images

_______ Initials

Attorney Medical Authorization:
I fully authorize Dr. Roderick White to discuss all information pertaining to my medical bills and records including diagnostic images, evaluations and case details with the law firm who is representing me for my case both verbally and in writing. This authorization is at my request. I may revoke this authorization at any time in writing. Revoking this request will not affect actions already taken in reliance upon this authorization form. Dr. Roderick White / Roderick White Chiropractic will follow HIPAA rules and regulations when handling information.

_______ Initials

Payment of Benefits:
I hereby authorize my insurance company to pay Dr. Roderick White for any benefits allowable as payment toward the total charges for professional services rendered. I instruct my insurance company to release medical payment benefits information to Dr. Roderick White including but not limited to medical payment policy limits.

_______ Initials

Messages:
Dr. Roderick White has my permission to contact me via phone/voicemail regarding medical matters & appointments ___Yes___No
Dr. Roderick White has my permission to email me regarding medical matters & appointments ___Yes___No
Dr. Roderick White has my permission to text me regarding medical matters & appointments ___Yes___No
Calls/Texts/Emails will be made according to the information provided on the "Patient Information Sheet"

_______ Initials

Office Policies:
I understand that Dr. Roderick White sees patients by appointments and not walk-ins. I understand that if I am early to my appointment, I might have to wait until my scheduled appointment time. I further understand that if I am more than 15 minutes late, my appointment will be rescheduled, I agree to contact Dr. Roderick White.

_______ Initials

Agreement:
By signing below I certify that I have read, understand and agree that all information provided is truthful and accurate to the best of my knowledge.

_______________________________ Patient/Parent/Guardian/Authorized Representative

_______________ Date

Name: ______________________ Today's Date: ______________________

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ☐ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ______________________

Ears, Nose, Mouth & Throat ☐ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ______________________

C-V (Heart & Blood Vessels) ☐ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ______________________

Resp. (Lungs & Breathing) ☐ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ______________________

GI (Stomach & Intestines) ☐ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ______________________

GU (Kidney & Bladder) ☐ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ______________________

MS (Muscles, Bones, Joints) ☐ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ______________________

Integ. (Skin, Hair & Breast) ☐ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ______________________

Neurologic (Brain & Nerves) ☐ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ______________________

Psychiatric (Mood & Thinking) ☐ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ______________________

Endocrinologic (Glands) ☐ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ______________________

Hematologic (Blood/Lymph) ☐ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: ______________________

Allergic/Immunologic ☐ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ______________________

RODERICK WHITE CHIROPRACTIC

COMPLAINT
(Initial Exam, Daily Note, Follow Up/Final Exam)

Complaint #__

Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the Other line.

Please grade pain 0-10 (10 is the highest) 0 1 2 3 4 5 6 7 8 9 10

RIGHT LEFT LEFT RIGHT

Other: ____________

This complaint came on:	□ Gradually	□ Immediately	
It is getting:	□ Improving	□ Staying the same	□ Getting Worse
The intensity of this complaint is:	□ Minimal □ Slight	□ Moderate	□ Severe
The frequency of this complaint is: □Intermittent	□ Occasional	□ Frequent	□ Constant
The pain is:	□ Dull	□ Sharp	□ Aching
	□ Shooting	□ Spasm	□ Throbbing
	□ Burning	□ Spasm	□ Tingling
The pain is located on:	□ Left side	□ Right side	□ Both sides
<u>Actions effecting this complaint:</u>			
Morning	□ Brings On	□ Aggravates	□ Relieves
Afternoon	□ Brings On	□ Aggravates	□ Relieves
Cold	□ Brings On	□ Aggravates	□ Relieves
Heat	□ Brings On	□ Aggravates	□ Relieves
Medication	□ Brings On	□ Aggravates	□ Relieves
Resting	□ Brings On	□ Aggravates	□ Relieves
Straining	□ Brings On	□ Aggravates	□ Relieves
Standing	□ Brings On	□ Aggravates	□ Relieves
Sitting	□ Brings On	□ Aggravates	□ Relieves
Lying down	□ Brings On	□ Aggravates	□ Relieves
Bending forward	□ Brings On	□ Aggravates	□ Relieves
Bending back	□ Brings On	□ Aggravates	□ Relieves
Bending left	□ Brings On	□ Aggravates	□ Relieves
Twisting left	□ Brings On	□ Aggravates	□ Relieves
Twisting right	□ Brings On	□ Aggravates	□ Relieves
Lifting	□ Brings On	□ Aggravates	□ Relieves
Coughing	□ Brings On	□ Aggravates	□ Relieves
Sneezing	□ Brings On	□ Aggravates	□ Relieves

INITIAL EVALUATION – Non Accident Related

LAST NAME: ____________________ FIRST NAME: __________________ MI: ____ Date: ________________

What brings you into our office? ☒ **Not accident related**

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities? ☐ Yes ☐ No

If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Activities of Daily Living — **Please select all activities which you are currently experiencing problems:**

☐ Seeing	☐ Tasting	☐ Smelling	☐ Eating	☐ Hearing	☐ Insomnia
☐ Dressing	☐ Reading	☐ Typing	☐ Writing	☐ Grasping	☐ Using the toilet
☐ Standing	☐ Leaning	☐ Walking	☐ Stooping	☐ Squatting	☐ Loss of sexual drive
☐ Bending	☐ Twisting	☐ Carrying	☐ Lifting	☐ Pushing	☐ Restful sleeping
☐ Sitting	☐ Driving	☐ Sports	☐ Exercising	☐ Reclining	☐ Loss of concentration
☐ Irritable	☐ Riding in car	☐ Air travel	☐ Climbing	☐ Pulling	☐ Changes in personality
☐ Grooming	☐ Pinching	☐ Kneeling	☐ Reaching	☐ Nervous	☐ Tactile feeling
☐ Bathing	☐ Holding				

INITIAL EVALUATION – Non Accident Related

RODERICK WHITE CHIROPRACTIC

Past Medical History Please select all conditions that you have had or are currently having:

◻ None	◻ Other	◻ Abdominal pain	◻ Weight gain/loss	◻ Angina
◻ Anorexia	◻ Anxiety	◻ Aortic aneurysm	◻ Arthritis	◻ Asthma
◻ Bladder infection	◻ Blood disorder	◻ Breast lumps	◻ Breast soreness	◻ Bronchitis
◻ Cancer	◻ Cardiovascular Dx	◻Chest pain	◻Chronic cough	◻ Chronic sinusitis
◻ Colitis	◻ Constipation	◻ Convulsions	◻COPD	◻ Depression
◻ Dermatitis, Eczema/Rash	◻ Diabetes	◻ Difficulty in swallowing	◻ Dizziness	◻ Emphysema
◻ Endometriosis	◻ Epilepsy	◻Excessive thirst	◻Fainting	◻ Frequent urination
◻ General fatigue	◻ Gout	◻ Hand pain	◻ Headache	◻ Heart attack
◻ Heart disease	◻ Heartburn/Indigestion	◻ Hepatitis	◻ High Blood Pressure	◻ High cholesterol
◻ High PSA	◻ High triglycerides	◻ Hypertension	◻ Irregular menstrual flow	◻ Irritable colon
◻ Jaw pain	◻ Kidney disorders	◻ Kidney stones	◻ Liver / Gallbladder Problems	◻ Loss of appetite
◻ Loss of bladder control	◻ Low back pain	◻ Lung disease	◻ Mental Disease	◻ Mid back pain
◻ Muscular in coordination	◻ Neck pain	◻ Osteoarthritis	◻ Pain in ankle or foot	◻ Pain in lower leg or knee
◻ Pain in upper arm or elbow	◻ Pain in upper leg and hip	◻ Painful urination	◻ PMS	◻ Pneumonia
◻ Profuse menstrual flow	◻ Prostate problems	◻ Rapid heartbeat	◻ Renal disease	◻Rheumatiod arthritis
◻Scoliosis	◻Shoulder pain	◻Stroke	◻ Swelling/stiffness joints	◻Thyroid disease of
◻Tinnitus/ ear noises	◻ Tuberculosis	◻ Tumor	◻ Ulcer	◻ Visual disturbances
◻Wrist pain				

RODERICK WHITE CHIROPRACTIC

INITIAL EVALUATION – Non Accident Related

Family History Please select all conditions that run in your family: ____________

▫ None	▫ Other	▫ Abdominal pain	▫ Weight Gain/loss	▫ Angina
▫ Anorexia	▫ Anxiety	▫ Aortic aneurysm	▫ Arthritis	▫ Asthma
▫ Bladder infection	▫ Blood disorder	▫ Breast lumps	▫ Breast soreness	▫ Bronchitis
▫ Cancer	▫ Cardiovascular Dx	▫ Chest pain	▫ Chronic cough	▫ Chronic Sinusitis
▫ Colitis	▫ Constipation	▫ Convulsions	▫ COPD	▫ Depression
▫ Dermatitis, Eczema/Rash	▫ Diabetes	▫ Difficulty swallowing	▫ Dizziness	▫ Emphysema
▫ Endometriosis	▫ Epilepsy	▫ Excessive thirst	▫ Fainting	▫ Frequent urination
▫ General fatigue	▫ Gout	▫ Hand pain	▫ Headache	▫ Heart attack
▫ Heart disease	▫ Heartburn/Indigestion	▫ Hepatitis	▫ HBP	▫ High cholesterol
▫ High PSA	▫ High triglycerides	▫ Hypertension	▫ Irregular menstrual flow	▫ Irritable colon
▫ Jaw pain	▫ Kidney disorders	▫ Kidney stones	▫ Liver/Gallbladder problems	▫ Loss of appetite
▫ Loss of bladder control	▫ Low back pain	▫ Lung disease	▫ Mental disease	▫ Mid back pain
▫ Muscular coordination	▫ Neck pain	▫ Osteoarthritis	▫ Pain in ankle or foot	▫ Pain in lower leg or knee
▫ Pain in upper arm or elbow	▫ Pain in upper leg and hip	▫ Painful urination	▫ PMS	▫ Pneumonia
▫ Profuse menstrual flow	▫ Prostate problems	▫ Rapid heartbeat	▫ Renal Dx	▫ Rheumatoid arthritis
▫ Scoliosis	▫ Shoulder pain	▫ Stroke	▫ Swelling/stiffness of joints	▫ Thyroid disease
▫ Tinnitus/ ear noises	▫ Tuberculosis	▫ Tumor	▫ Ulcer	▫ Visual disturbances
▫ Wrist pain				

INITIAL EVALUATION – Non Accident Related

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Surgical History Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee Surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

☐ Surgical History was reviewed:
Not contributory

Medications Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies Please select all items that you are allergic to:

☐ None	☐ Other	☐ Chemical	☐ Environmental
☐ Food	☐ Medication	☐ Seasonal	

Social History Please answer the following questions:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have any children? ☐ Yes ☐ No If yes, how many? ______

Do you use: ☐ Tobacco ☐ Alcohol ☐ Coffee