Creek Chiropractic, LLC
Brian Briggs, DC
1911 N. Fairfield Rd. Ste. 230
Beavercreek, OH 45432
Phone (937) 988-0008 Fax (937) 702-3505
www.creekchiropractic.com

CONFIDENTIAL PATIENT CASE HISTORY

Welcome to our office. Please complete this information as thoroughly as possible. We don't just treat symptoms, we treat causes, and this information will help us get a better understanding of your overall health. If at any point you have any questions, our staff will be happy to assist you.
Thank you!

PERSONAL INFORMATION

Name:_____ **Preferred Name:**_____ **Date:**_____

Date of Birth:___/ _____/ _____ **Age**:_____ **Sex**: ☐Male☐Female **Marital Status**: S / M/ D/ W

Address: _____

City:_____ **State**:____ **Zip Code**:_____

Social Security Number:_____-_____-_____ **Home Phone**: (_____) _____

Cell Phone: (_____) _____ **E-mail**: _____

Occupation:_____ **Employer**: _____

Employer Address: _____

Work Phone: (_____) _____

Spouse's Name: _____ **Date of Birth**: _____/ _____/____ **Age**: _____

Spouse's Employer: _____ **Employer Address**: _____

Spouse's Social Security Number (only needed if on spouse's insurance): _____-_____-_____

Emergency Contact:_____

Emergency Contact Phone: (_____) _____ **Relationship**:_____

How did you hear about us? ☐Friend ☐Family Member ☐Google Search
☐Website ☐Drive-by ☐Facebook
☐Other Social Media ☐Other:_____

Who may we thank for referring you? _____

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom? _____

When did this condition begin/become exacerbated (date)? _____

Have you had this or similar conditions in the past? _____

What do you think caused this condition? _____

What positions make your pain worse (sitting, standing, walking, bending, etc.)? _____

What positions make your pain better (ice, heat, resting, sitting, stretching, etc.)? _____

Over time, is this condition: ☐Improving ☐Unchanged ☐Getting Worse

What Activities of Daily Living is this condition interfering with?

☐Bathing	☐Chores/Farm work	☐Cleaning house	☐Climbing stairs	☐Dishes
☐Driving	☐Exercising	☐Getting Dressed	☐Getting in/out of vehicle	☐Grocery shopping
☐Lifting children	☐Sitting	☐Sleeping	☐Standing	☐Tying shoes
☐Walking	☐Working	☐Yardwork	☐None	

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CURRENT PRIMARY HEALTH CONCERN

Patient Name: _____

Have you sought advice or treatment from other doctors or therapists for **THIS** condition? ☐Yes ☐No

If yes, list all doctors or therapists consulted for **this** condition (include approximate date of visit and diagnosis):

Name	Date of Visit	Diagnosis

Describe any treatment you have had for **THIS** condition (include medication dosage & frequency): _____

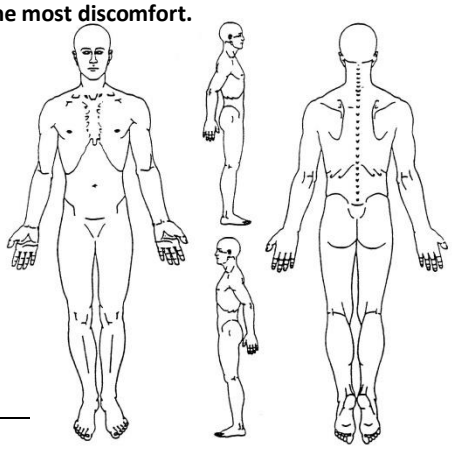
Family Medical Doctor: _____ Office Name/Location: _____

Date of Last Physical: _____

May we communicate our findings on your current health condition to the above provider(s)? ☐Yes ☐No

Days lost from work due to this condition: _____

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a sale of 1-10, with 1 being the least discomfort and 10 being the most discomfort.



Primary Complaint:
1. _____ **1 2 3 4 5 6 7 8 9 10**

Additional Complaints:
2. _____ **1 2 3 4 5 6 7 8 9 10**
3. _____ **1 2 3 4 5 6 7 8 9 10**
4. _____ **1 2 3 4 5 6 7 8 9 10**
5. _____ **1 2 3 4 5 6 7 8 9 10**

Have you sought care for a **DIFFERENT** health condition in the past year? ☐Yes ☐No
In the past 2 years? ☐Yes ☐No
If yes, for what condition? _____
Was treatment administered? ☐Yes ☐No Describe: _____

Do you take medications: ☐Yes ☐No List medication, dosage, frequency & reason: _____

Any prior hospitalizations or surgeries: ☐Yes ☐No Describe with dates: _____

Have you been in an auto accident or had any other personal injuries? ☐Yes ☐No Describe: _____

CHIROPRACTIC HISTORY

Previous Chiropractic Care? ☐Yes ☐No If yes, Doctor's Name: _____

Date of last chiropractic visit: ____/ ____/ ____ Date of last spinal x-rays: ____/ ____/ ____

Reason for care: _____ How long were you under care? _____

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SOCIAL HISTORY

Staff Only: BP:_____/_____ BPM:_____ ☐Left Arm ☐Right Arm

Height:____ft. ____in. Current Weight:_____lbs. Have you recently lost/gained more than 10 lbs? ☐Yes ☐No
Are you: ☐Left-handed ☐Right-handed ☐Ambidextrous

Mental Work: ☐Heavy ☐Moderate ☐Light Hours per day:_____
Physical Work: ☐Heavy ☐Moderate ☐Light Hours per day:_____
Exercise: ☐Heavy ☐Moderate ☐Light Hours per week:_____ Type:_____
Tobacco: ☐Never ☐Currently ☐Previously Packs/dips per day_____ How long?:____
Alcohol: ☐None ☐Beer/week:_____ ☐Liquor/week:_____ ☐Wine/week:____
Caffeine: ☐None ☐Cups/day:_____
Aspirin: ☐Yes ☐No How many per day?:_____

FAMILY HISTORY – List any diseases which run in your family

Relative	Age if Living	Age at Death	Cause of Death	Illnesses/Diseases
Father:				
Mother:				
Brother(s):				
Sister(s):				
Grandfather (Mat.):				
Grandmother (Mat.):				
Grandfather (Pat.):				
Grandmother (Pat.):				

Your Overall Health Status: ☐Poor ☐Fair ☐Good ☐Excellent

INSURANCE INFORMATION – If you have provided Staff with a copy of your insurance card(s), skip this section.

Who is responsible for this account?: _____
Relationship to Patient:_____ Date of Birth: _____
Insurance Co:_____Patient ID #:_____Group #:_____
Is Patient covered by additional or secondary insurance? ☐Yes ☐No
Subscriber's Name: _____
Relationship to Patient:_____ Date of Birth: _____
Insurance Co:_____Patient ID #:_____Group #:_____

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REVIEW OF SYSTEMS (NOW = within the past 1 year; PAST = over 1 year ago)

Patient Name:_____

GENERAL	Now	Past
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐
HEAD & EYES		
Headaches	☐	☐
Injuries	☐	☐
Last Eye Exam Date:	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐
THROAT		
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐

BREASTS	Now	Past
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐
RESPIRATORY		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant exposure	☐	☐
CARDIOVASCULAR		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremity	☐	☐
Cold Extremities	☐	☐
Chest Pain/Press	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
GASTROINTESTINAL		
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloating	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irreg. Bowel	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Pain with Urination	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Spotting	☐	☐
Menstrual Cramp	☐	☐
Painful Periods	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irreg. Periods	☐	☐

NEUROLOGICAL	Now	Past
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Incoordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficult Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐
ENDOCRINE		
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐
IMMUNIZATION/VACCINATION		
DPT	☐	☐
Mumps	☐	☐
Small Pox	☐	☐
Typhoid	☐	☐
Tetanus	☐	☐
Measles	☐	☐
Pneumococcal	☐	☐
Influenza	☐	☐
Polio	☐	☐
MMR	☐	☐
Covid-19	☐	☐
PSYCHIATRIC		
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Trouble Sleeping	☐	☐
Irritable	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
MUSCULOSKELETAL		
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Stiffness	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

PAST MEDICAL HISTORY

Check only the ones you have had in the past

Hay Fever	☐
Mumps	☐
Rheumatic Fever	☐
Allergies	☐
Angina	☐
Cancer	☐
Tumor	☐
Blood Disease	☐
Leukemia	☐
Heart Trouble	☐
Varicose Veins	☐
Phlebitis	☐
Hypertension	☐
Stroke	☐
Ulcers	☐
Jaundice	☐
Skin Trouble	☐
Gallstones	☐
Liver Trouble	☐
Hepatitis	☐
Parasites	☐
Epilepsy	☐
Paralysis	☐
Polio	☐
Mental Illness	☐
Alcoholism	☐
Depression	☐
Nervous Break	☐
Migraine	☐
Covid-19	☐
Gout	☐
Hemorrhoids	☐
Prostate Problems	☐
Gonorrhea	☐
Syphilis	☐
Diabetes	☐
Bladder Trouble	☐
Kidney Stones	☐
Kidney Infection	☐
Dysentery	☐

ALLERGIES

List known allergies below; indicate **NONE** if there are no known allergies

_____
_____
_____
_____
_____
_____

If FEMALE,
Are you Pregnant?
☐**Yes**
☐**No**

If Yes, what is your approx. due date? _____
How many weeks are you? _____
Is this your first pregnancy? ☐Yes ☐No

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ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email, phone, and text message in regards to treatment as well as promotional activities. This clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.

_____ Initial

AGREEMENTS and AUTHORIZATION

Consent to Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professional and assistants employed or otherwise retained by this office. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____ Initial

Payment Guarantee

In consideration of the services provided by this office, Provider to Patient, you agree to: 1) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); 2) irrevocably assign and transfer to this office, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and 3) authorize payment of such benefits directly to this office. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

_____ Initial

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance, massage and any services beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ Initial

Patient Right to Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on your behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ Initial

Responsibility for Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by this office for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

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AUTHORIZATION and HIPAA PRIVACY NOTICE

Consent to Release Information

Here at this office, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries. It is understood and agreed that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient of Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ Initial

HIPAA Privacy Notice Patient Acknowledgement

Patient Acknowledgment and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
2) The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
5) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's website. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ Initial

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____