Confidential Patient Case History

DATE_____ NAME_____SS#_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE (_____)_____ DATE OF BIRTH_____ AGE_____ ☐ M ☐ F

EMPLOYER_____ WORK PHONE (_____)_____

MARITAL STATUS: S M D W NUMBER OF CHILDREN _____ SPOUSE'S NAME_____

PRIMARY CARE PHYSICIAN'S NAME (First & Last) _____
ADDRESS & PHONE NUMBER _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____ REFERRED BY_____

Please check the appropriate box for any of the following symptoms you now have or have had previously. THIS IS A CONFIDENTIAL HEALTH REPORT.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Stroke	☐	☐	Smoking/Use of Tobacco Products
☐	☐	Neck Pain	☐	☐	Angina			How Much?_____
☐	☐	Upper Back Pain	☐	☐	Kidney Stones			For How Long?_____
☐	☐	Mid Back Pain	☐	☐	Kidney Disorders	☐	☐	Drug Dependence
☐	☐	Low Back Pain	☐	☐	Bladder Infection			What type?_____
☐	☐	Shoulder Pain	☐	☐	Painful Urination			How much?_____
☐	☐	Elbow/Upper Arm Pain	☐	☐	Loss of Bladder Control			For How Long?_____
☐	☐	Wrist Pain	☐	☐	Prostate Problems	☐	☐	Alcohol Dependence
☐	☐	Hand Pain	☐	☐	Abnormal Weight Loss/Gain			How much?_____
☐	☐	Hip/Upper Leg Pain	☐	☐	Loss of Appetite			For How Long?_____
☐	☐	Knee/Lower Leg Pain	☐	☐	Abdominal Pain	☐	☐	Caffeine Intake
☐	☐	Ankle/Foot Pain	☐	☐	Ulcer			How much?_____
☐	☐	Jaw Pain	☐	☐	Hepatitis			For How Long?_____
☐	☐	Joint Swelling or Stiffness	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Allergies-To what?_____
☐	☐	Arthritis	☐	☐	Cancer	☐	☐	Depression
☐	☐	Rheumatoid Arthritis	☐	☐	Tumor	☐	☐	Systemic Lupus
☐	☐	General Fatigue	☐	☐	Asthma	☐	☐	Epilepsy
☐	☐	Muscular Incoordination	☐	☐	Chronic Sinusitis	☐	☐	Dermatitis/Eczema/Psoriasis/Rash
☐	☐	Visual Disturbances	☐	☐	Diabetes	**Females Only**		
☐	☐	Dizziness	☐	☐	Excessive Thirst	☐	☐	Birth Control TYPE:_____
☐	☐	High Blood Pressure	☐	☐	Frequent Urination	☐	☐	Hormonal Replacement
☐	☐	Heart Attack	☐	☐	HIV/AIDS	# Pregnancies____ # of Live Deliveries____		
☐	☐	Chest Pains	☐	☐	Multiple Sclerosis	Are you or could you be pregnant?_____		

Other Health Problems / Issues?_____
_____

Have you ever had previous chiropractic care? ☐ Yes ☐ No When and With whom?_____

What is your major complaint?_____

How long have you had this condition?_____ Have you had this or similar conditions in the past?_____

Is this condition getting progressively worse? ☐ Yes ☐ No Is the condition ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

Did you do anything specific that brought this on?_____

Other complaints_____

List surgical procedures with dates: _____

List any current medications you are taking, and why: _____
_____

Have you ever had any mental or emotional disorders? ☐ No ☐ Yes What and When?_____

Have others in your family had such disorders? ☐ No ☐ Yes When?_____

Have you ever been hospitalized (other than surgery)? ☐ No ☐ Yes Describe Briefly_____
_____

FAMILY HEALTH INFORMATION (Many health problems can be genetic thus information about your family members; Mother, Father, Siblings, and Children, will give us a better picture of your total health picture.) *Continue on back of sheet if necessary*.

NAME	RELATION	HEALTH PROBLEM

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):

Name_____ Relationship_____ Phone (_____)_____

Address_____

NEW BERLIN
CHIROPRACTIC &
THERAPY CENTER

Dr. James Koshick, DC
Dr. Johan Albert, DC

15800 W National Ave
New Berlin, WI 53151
T:(262)785-8989
F:(262)785-8992

Medical Information Release Form/HIPAA Form

Name: _____ Date of Birth: ____/____/_____

This is to acknowledge that I (Print Name)_____ have been given the opportunity to review the New Berlin Chiropractic HIPAA and Notice of Privacy Practices and I have been given and/or offered a copy of the HIPAA and Privacy Notice tri-fold for my personal records.

Release of Information

{ } I authorize the release of information including the diagnosis, future appointments, Billing/Balance on account, records, examination rendered to me and claims information. This information may be released to:

{ } Spouse _____
{ } Child(ren) _____
{ } Other _____
Names_____

{ } Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call { } Home_____ { } Work _____ { } Cell _____

If unable to reach me:

{ } you may leave a detailed message

{ } Please leave a message asking me to return your call

The best time to reach me is (Day) _____, between (time)_____

_____ Date _____
Signature of Patient

_____
Legal Guardian/Parent if under 18 years of age

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound and exercises, traction or massage therapy may also be used.

Possible risk: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stoke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options that could be considered may include the following*:*

- *Over-the-counter analgesics*. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Patient Name _____ **If minor, Guardian Name**: _____
Patient Signature/Guardian (if minor) _____ **Date:** _____

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DISCOUNTED SELF-PAY POLICY

Thank you for choosing our discounted self-pay plan for your services. Our policy for self-pay patients is to collect at the time that services are rendered. Please know that we will not submit any claims to your insurance company nor will we be able to give you a printout for you to submit yourself.

Personal injury cases (auto injury, workman's comp, etc) do not qualify for this plan. By doing this, we are able to reduce our administration fees and therefore able to extend our savings to you.

Prices - - Effective January 1st 2018

Adjustment (includes 1 therapy, excludes massage):	$45
Additional therapy:	$5
1st Visit Consultation, Examination, X-rays (1 area):	$99
Re-examinations:	50% off regular price
X-rays:	50% off regular price
Massage Therapy w/ Adjustment	30 min: $25 60 min: $50

Patient Name:_____

Patient/or Guardian Signature:_____ Date:_____