



**CONFIDENTIAL PATIENT CASE HISTORY**

**Dear Patient:**

**Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU!**

**PERSONAL INFORMATION:**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_  
Cell # \_\_\_\_\_ Do you accept text messages? \_\_\_\_\_ E- Mail Address \_\_\_\_\_  
Best time of day to reach you \_\_\_\_\_ am/pm Best form of contact \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_  
Age \_\_\_\_\_ Birth date \_\_/\_\_/\_\_\_\_ # Children \_\_\_\_\_ Marital Status M / S / W / D Occupation \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Spouse's Office Telephone \_\_\_\_\_  
Referred by \_\_\_\_\_ Emergency Contact \_\_\_\_\_

**HEALTH INFORMATION:**

Have you had previous chiropractic care? \_\_\_\_\_  
What is your primary reason for today's visit?  
\_\_\_\_\_  
\_\_\_\_\_  
Other complaints: \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_  
What aggravates your condition? \_\_\_\_\_  
Is this condition getting progressively worse? Yes  No  Constant  Comes and goes   
Is this condition interfering with your Work  Sleep  Daily Routine  Other \_\_\_\_\_  
How long has it been since you really felt good? \_\_\_\_\_  
Other doctors who treated this condition \_\_\_\_\_  
Age of mattress \_\_\_\_\_  Comfortable  Uncomfortable Do you currently wear  Heel lifts  Orthotics  Arch supports

Please list **All** medications you currently take: \_\_\_\_\_

Please list **All** Vitamins/Herbs you now take: \_\_\_\_\_

Have you been in an auto accident?       Past year       Past 5 years       Over 5 years       Never

Describe \_\_\_\_\_

Have you had any other personal injury or accident?    Past year       Past 5 years       Over 5 years

Describe \_\_\_\_\_

Date of Last Physical Examination: \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Information about you immediate family members, Brothers, Sisters, Parents, Grandparents will give us a better understanding of your total health picture.

**RELATIONSHIP**

**PRESENT & PAST HEALTH PROBLEMS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY** – Please list **All** surgeries, pregnancies, illnesses, childhood diseases, etc. Please use back of page if more space is needed.

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY** – Example: Smoking, Drinking, current level of exercise and activity..... How much / How long?

\_\_\_\_\_  
\_\_\_\_\_

**RELATED HEALTH HISTORY**

**\*SOME HEALTH CONDITIONS ARE A RESULT OF OUR ENVIRONMENT IN THE WAY WE LIVE AND WORK.**

**LIST ANY ELECTRICAL ITEMS YOU MAY USE AT HOME OR AT WORK.  
ELECTRIC BLANKETS, HEATING PADS, COMPUTERS, DIAGNOSTIC MACHINERY, ETC.**

---

---

**LIST ANY CHEMICALS YOU USE AROUND THE HOME OR AT WORK.  
PAINT, VARNISH, PHOTOGRAPHY CHEMICALS, FERTILIZER, PESTICIDE SPRAYS, ASBESTOS, ETC.**

---

---

**DO YOU HAVE ANY SILVER/MERCURY FILLINGS? IF SO, HOW LONG HAVE YOU HAD THEM?**

---

**INSURANCE INFORMATION**

Is your condition due to an auto accident or job related injury?       Yes       No

Do you have Health Insurance?     Yes       No      If yes,

Name of Company \_\_\_\_\_ Policy # \_\_\_\_\_

Are you covered by Medicare?     Yes       No

If yes, Health Insurance # \_\_\_\_\_

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION FOR CARE OF A MINOR**

I hereby authorize Koster Family Chiropractic, LLC, Dr. Michael J. Koster and whomever they may designate to administer care as they deem necessary to my son / daughter.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

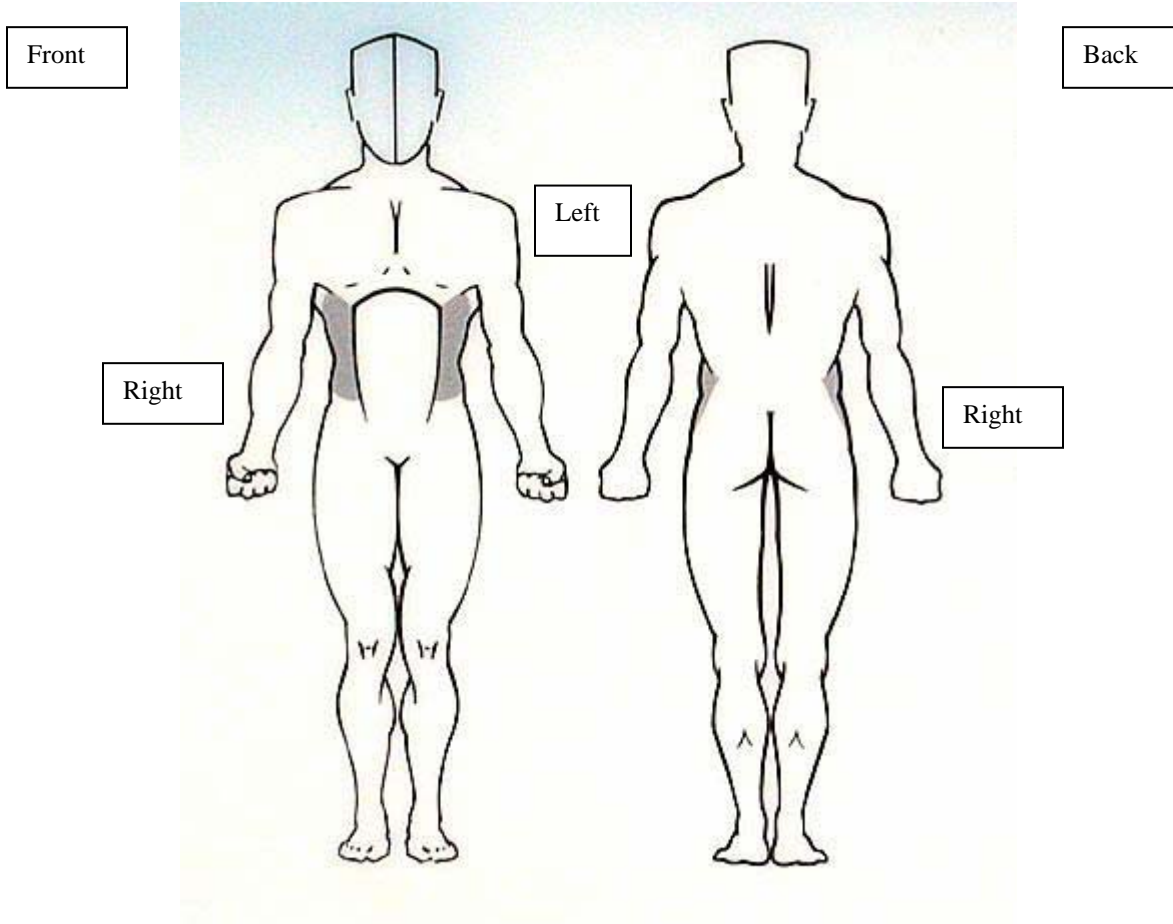
Date: \_\_\_\_\_

Mark the areas on your body where you feel the following sensations:

Pain **XXX**  
Burning **BBB**

Numbness **OOO**  
Stabbing **///**

Pins and Needles **---**  
Other **+++**



### Visual Analog Scale

Indicate the severity of your pain by marking an "X" at the appropriate point on pain line  
0 is "NO PAIN" and 10 is the "WORST PAIN" you have ever felt.

How bad is your neck pain now?



How bad is your back pain now?



How bad is your arm pain now?



How bad is your leg pain now?





*From the office of Dr. Michael J. Koster...*

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at Koster Family Chiropractic we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

Your name, address, telephone number, e-mail address and health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have the right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.





*Patient Authorization regarding chiropractic care and physiotherapy, being provided in an “open treatment” environment...*

It is the practice of this office to provide health care in an “open treatment” environment. “Open treatment” involves several patients being in the same room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for consultation, history taking, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosure” of health information. It is our view that the kinds of matters related in an “open treatment” environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive, as well as to enhance your access to quality health care and health information. If you choose not to be treated in an open treatment environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Koster or on your relationship with our staff.

Your signature indicates your authorization of this activity.

\_\_\_\_\_

Name (printed)

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.