CASE HISTORY

Name_____ Date_____
Address_____ City_____ State____ Zip_____
Home Phone_____ Cell Phone_____
E-Mail_____ Social Security #_____
Age_____ Birthdate _____ Sex_____ Status M S W D No. Children_____
Occupation_____ Employer_____ Years Employed_____
Employer's Address_____ City_____ State___ Phone_____
Spouse's Name_____ Occupation_____ Employer_____
Person responsible for account_____ Referred by_____
What is your major complaint?_____
_____
Other complaints_____
How long have you had this condition?_____ Have you had similar conditions in past?_____
What aggravates your condition?_____
Is this condition 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 have felt really good?_____
List surgical operations:_____
_____
Are you taking medications?_____ What kind?_____
Any non-prescription drugs?_____ What kind?_____
OTHER DOCTORS SEEN FOR THIS CONDITION: MD____ DC____ DO____ DDS_____
Doctor's Name_____ Diagnosis_____
X-Rays_____ Urinalysis_____ Blood Tests_____ Other_____
Treatment: Medication_____ Physiotherapy_____
Results_____ Length of time under care_____
Were you off work?_____ If so, how long?_____ Have you returned to same job?_____
If not, why?_____

AUTHORIZATION FOR CHIROPRACTIC/ACUPUNCTURE TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. Michael J. Wolff (and whomever he may designate as his assistants) to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic or Acupuncture Treatment, the reasons why the above named treatment is necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Wolff.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Signed_____ Date_____

Witness_____

IMPORTANT: Please circle all present symptoms

HEAD:
Headache
- Sinus(allergy)
- Entire head
- Back of head
- Forehead
- Temples
- Migraine

Head feel heavy
Loss of memory
Fainting
Light bothers eyes
Blurred vision
Double vision
Loss of vision
Loss of taste
Loss of balance
Dizziness
Loss of hearing
Pain in ears
Ringing in ears
Buzzing in ears

NECK:
Pain in neck
- Forward
- Backward
- Turn to left
- Turn to right
- Bend to left
- Bend to right

Pinched nerve in neck
Neck feels out of place
Muscle spasms in neck
Grinding sounds in neck
Popping sounds in neck
Arthritis in neck

SHOULDERS:
Pain in shoulder joint(R or L)
Pain across shoulders
Bursitis(R or L)
Arthritis(R or L)
Can't raise arm
- Above shoulder level
- Over head

Tension in shoulders
Pinched nerve in shoulder (R of L)
Muscle spasms in shoulder

ARMS & HANDS:
Pain in upper arm
Pain in elbow
Movement aggravated
Tennis elbow
Pain in forearm
Pain in hands
Pain in fingers
Sensation of pins & needles in arms
Sensation of pins & needles in fingers
Numbness in arms (R or L)
Numbness in fingers (R or L)
Fingers go to sleep
Hands cold
Swollen joints in fingers
Sore joints in fingers
Arthritis in fingers
Loss of grip strength

MID-BACK:
Mid-back pain
Location_____
Pain between shoulder blades
Sharp stabbing
Dull ache
Pain from front to back
Muscle spasms
Pain in kidney area

CHEST:
Chest pain
Shortness of breath
Pain around ribs
Breast pain
Dimpled or orange peel breast
Irregular heartbeat

ABDOMEN:
Nervous stomach
Foods can't eat_____
Nausea
Gas
Constipation
Diarrhea
Hemorrhoids

LOW-BACK:
Low back pain
- Upper lumbar
- Lower lumbar
- Sacroiliac

Low back pain is worse when:
- Working
- Lifting
- Stooping
- Sitting
- Bending
- Coughing
- Lying down (sleeping)
- Walking

Pain relieves when_____
Slipped disc
Low back feels out of place
Muscle spasms
Arthritis

HIPS, LEGS & FEET:
Pain in buttocks (R or L)
Pain in hip joint (R or L)
Pain down leg (R or L)
Pain down both legs
Knee pain
- Inside
- Outside

Leg cramps
Cramps in feet (R or L)
Pins & needles in legs (R or L)
Numbness of leg (R or L)
Numbness of feet (R or L)
Numbness of toes
Feet feel cold
Swollen ankles (R or L)
Swollen feet (R or L)

WOMEN ONLY:
Menstrual pain_____where?
Cramping
Irregularity
Cycle_____days
Birth control_____type
Hysterectomy
Genital cancer
Discharge
Menopause
Tunors
Abortions
Are you or do you think you might be pregnant?

MEN ONLY:
Urinary frequency
Difficulty instarting
Night urination
Prostate pain/swelling

GENERAL:
Nervousness
Irritable
Depressed
Fatigue
Generally feel run down
Normal sleep_____hrs./night
Loss of sleep_____hrs./night
Loss of weight_____lbs.
Gain weight_____lbs.
Coffee_____cups a day
Tea_____cups a day
Cigarettes_____pack/day
Other_____
Diabetes
Hypoglycemia

REMARKS:

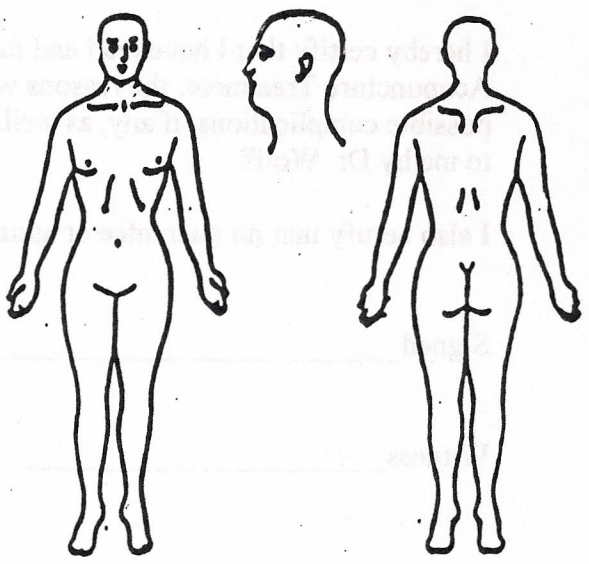
_____

_____

_____

_____

_____



BETTER HEALTH CENTER

Michael J. Wolff, D.C., F.I.A.C.A, F.I.C.P.A.

Statement of Policies and Practice

1. We are a natural chiropractic and physiotherapy practice, employing natural healing adjustments.
2. We do not perform any form of allopathic drug/surgery procedures.
3. As people respond differently to treatments, there is no "guarantee" implicitly or explicitly associated.
4. The information provided conforms to the best, latest, available and acceptable natural healing practices/procedures.
5. Acceptance of treatment does not preclude other supplementary forms of treatment.
6. On occasion, various degrees of discomfort may be experienced as part of the healing process.
7. While patient records may be reviewed by any clinic practitioner, all information will be held in the strictest confidence.
8. All services rendered are on a cash basis unless specific arrangements are made with the staff prior to treatment. Visa, MasterCard, and Discover Card are accepted.
9. Nearly all insurance policies provide chiropractic coverage, however, due to the increasing costs and subsequent losses associated with managing and processing claims, we ask that you file claims with your insurance company. We will provide you with the necessary paperwork to do so.
10. All patients must sign in before seeing the doctor, and check out with the staff before leaving the office.
11. A $20.00 inconvenience charge will be placed on all returned checks.

I have fully read and understand the above information. I voluntarily affix my signature and the date below.

Signed_____Date_____

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Dr. Michael J. Wolff ("the Practice")to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator, or managed care company.

X _____ _____

Patient Signature *Date*

X _____ _____

Printed Name *Date of Birth*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discus your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals:

_____ _____

Name *Relationship to Patient*

_____ _____

Name *Relationship to Patient*

X _____ _____

Patient Signature *Date*

_____ _____

Witness *Date*

I understand that I am entitled to a copy of a "Notice of Privacy Practices".

X _____ _____

Signature *Date*