A Fax From:

4010 NW Cache Road ~ Lawton, OK 73505
Phone: 580-357-8688 ~ Fax: 580-357-7483

FAX NUMBER: ________________________________PAGES: (including cover page): _______
DATE: _______________ATTENTION: ____________________FROM: ____________________

Request for Medical Records

By signature below I authorize:

____________________________________to release identifiable information from the medical record(s) of: (Patient's Name) ___________________________ to Case Chiropractic, 4010 NW Cache Road, Lawton, OK 73505.

Or, By signature below I authorize:

Case Chiropractic to release identifiable information from the medical record(s) of: (Patient's Name) ___________________________ to _________________________________.

Describe protected health information, date, type, or origin:

____

This protected health information is being used or disclosed for the following purposes: The evaluation and diagnosis of my health.

This authorization shall be in force and effect until ______________________________.

The information authorized for release may include information, which may be considered a communicable, or venereal disease, which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus know as acquired immune deficiency syndrome (AIDS).

____	_______________________
Signature of Patient or Personal Representative	Date
____	_______________________
Print Name of Patient or Personal Representative	Social Security Number
____	_______________________
Description of personal Representative's Authority	Patient's Date of Birth CC: Patient

The information contained in the transmission accompanying this notice is confidential and protected by the physician and patient privilege. It is intended only for the use of the individual or entity identified below. If the render of this message is not the intended recipient, you are

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hereby notified that any dissemination or distribution of the accompanying communication is prohibited. The parties sending the accompanying documents do not waive the physician and patient privilege. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address below via the United States Postal Service.

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Date:_________________Patient#_______________

Chiropractic Patient Information

Name: ____________________Address (mailing): _________________City: _____________
State: ______ Zip :________+(4)_______ Home Phone: ______________Cell _____________
E-mail address: ____

Race (Check 1):

American Indian	White	Native Hawaiian
Alaskan Native	Black	Pacific Islander
Asian	African American	Other
		Declined to State

Ethnicity (Check 1)
Hispanic or Latino Not Hispanic or Latino Declined to State
Preferred Language: ____________

Marital: __________ Age: _____ Birth Date: ________Social Security #___________________

How were you referred to our office?
____

Occupation: ____________ Employer: ____________Employer's Address: ________________
Work Phone: _____________________________

Spouse:___________________ Occupation:______________ Employer:__________________
Emergency Contact: ______________________ Address: ____________________________
Phone:___________________

HISTORY OF PRESENT ILLNESS: List in order of severity if more than one:
Chief Complaint: (Purpose of this appointment):
____
Date symptoms appeared or accident happened:
____

Is this due to: □Auto □Work □Other: ____
Days lost from work: __________
Have you ever had the same or a similar condition? □ Yes □ No If yes, when:
____

Treatment already received: □ Medication □ Physical Therapy □ Surgery □ Chiropractic □ None □ Other
Rate your pain on a scale of 1 to 10. _________

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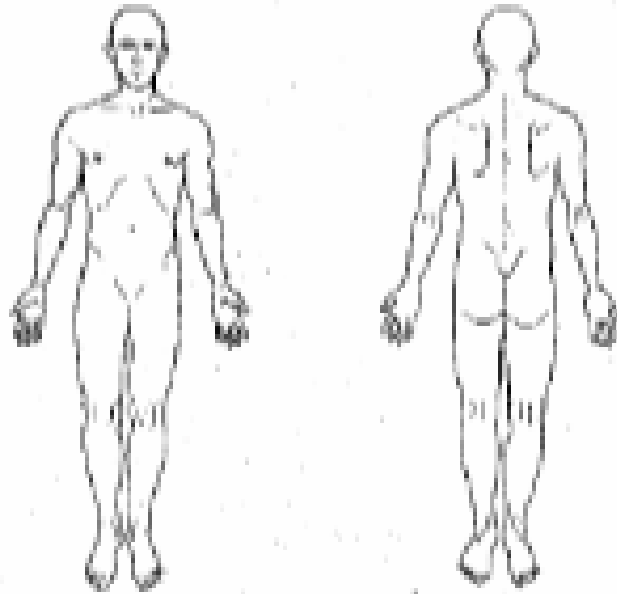
Does this pain affect you: constantly______ intermittently_________

Name and address of Doctor(s) who have treated you:
____
Date of last: Physical examination: _________ Spinal Exam: ________ Spinal X Rays: _______
Chest X Rays: ________MRI________ CT_______Bone Density ______Bone Scan_________
Blood Test: _______ Urine Test: _____________

Please Indicate Region of Complaint
◻ HEADACHE PAIN ◻ NECK PAIN
◻ LOW BACK PAIN ◻ SHOULDER PAIN
◻ ELBOW PAIN ◻ WRIST PAIN
◻ HAND PAIN ◻ HIP PAIN
◻ KNEE PAIN ◻ ANKLE PAIN
◻ FOOT PAIN ◻ TMJ
◻ UPPER/MID BACK PAIN
◻ OTHER ______________________



Use the letters listed below to indicate the type and location of your pain and sensations...
KEY
A = ACHE B = B BURNING
S = STABBING N = NUMBNESS
P = PINS & NEEDLES
O = OTHER
____

PAST MEDICAL HISTORY
Have you ever been diagnosed as having or have suffered from? (Place a check all conditions that apply to you)
◻ Broken or Fractured Bones ◻ Osteoarthritis ◻ Eating Disorder ◻ Heart Disease ◻ Prosthesis
◻ Circulatory Problems ◻ Osteoporosis ◻ Alcoholism ◻ COPD ◻ Psychiatric Care
◻ Rheumatoid Arthritis ◻ Pace Maker ◻ Drug Addiction ◻ Migraines ◻ Thyroid
◻ Seizures/Convulsions ◻ Diabetes ◻ HIV Positive ◻ Vaginal Infections ◻ STD
◻ A Congenital Disease ◻ Cancer ◻ Gall Bladder ◻ Ulcer ◻ Kidney disease
◻ Excessive Bleeding ◻ Ruptures ◻ Depression ◻ Prostate ◻ Reflux
◻ High ◻ Low Blood Pressure ◻ Coughing Blood ◻ Epilepsy ◻ Liver Disease ◻ Other________
Do you have a history of stroke or hypertension? _____________________________________

Patient’s Initials ________________

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Date: ___________Patient Name: ______________________Patient #____________________
Are you currently taking any medications, including over the counter? Yes No
If Yes, please indicate the following:

Medication: _____________mg____
Route: (Check 1) Oral Tab Capsule Intravenous Other: ___________
Frequency: _____________________
Began Use: ____________________ Discontinued Use: _______________

Medication: _____________mg____
Route: (Check 1) Oral Tab Capsule Intravenous Other: ___________
Frequency: _____________________
Began Use: ____________________ Discontinued Use: _______________

Medication: _____________mg____
Route: (Check 1) Oral Tab Capsule Intravenous Other: ___________
Frequency: _____________________
Began Use: ____________________ Discontinued Use: _______________

If there are more than three medications we can call your pharmacy for your list or bring all bottles on next visit.

Do you have any allergies to medication? Yes No
If Yes, please indicate the following:

MEDICATION ALLERGIES

____
____
____

SEASONAL ALLERGIES

____
____
____

VITAMINS/HERBS/MINERALS

____
____
____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK/HOME ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Alcohol: Drinks/Day _____
- ☐ Caffeine: Drinks/Day _____
- ☐ High Stress Level: Reason?

____

HOBBIES:

____

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SURGERIES/INJURIES	**Description**	**Date**
Falls	________________________________	____________
Head Injuries	________________________________	____________
Broken Bones	________________________________	____________
Dislocations	________________________________	____________
Surgeries	________________________________	____________

Please list any other health problems you have, no matter how insignificant they may be:
____

What percentage of time during the day (at home / your job / away from home) do you spend?
Lifting: ________ Pulling ________ Pushing ______ Sitting: ________ Bending: _________
Working at a computer: ___________

FAMILY HISTORY Parents: (check one)
Father: □ living □ deceased □ Current age if still living: _______
Cause of death and age at death if deceased: _______________________
Mother: □ living □ deceased □ Current age if still living: _______
Cause of death and age at death if deceased: _______________________
Do you have any family members who suffer from the same condition you do? □ Yes □ No If so, please list:

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):
_______ Tuberculosis _______ Cancer _______ Mental Illness _______ Kidney Disease
_______ Diabetes _______ Asthma _______ Heart Disease _______ Liver Disease
_______ Stroke _______ Arthritis _______ Lung Disease _______ Other
Please check any and all insurance coverage applicable in this case:
□ Major Medical □ Medicare □ Medigap/supplemental □ Medicare secondary insurance □ Auto Accident □ Worker's Comp □ Medical Savings Acct & Flex Plans □ Other

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Case Chiropractic. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.
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. I authorize Case Chiropractic to communicate with my primary care physician and to use my name on a referral board when I refer. 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. If there is anyone you do not want to receive your medical records, please inform our office.
□ **Check this box of you would like to have access to your Electronic Health Records**
Patient's Signature ____ Date ______________
Guardian's Signature Authorizing Care _________________________ Date ______________

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Neck Disability Index

Date: __________Patient Name: _____________________Patient #___________________

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (Washing Dressing, etc)

A. I can look after myself normally, without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it gives extra pain.
C. Pain prevents me from lifting heavy weights off the floor, but I can
manage if they are conveniently positioned, for example, on a
table.
D. Pain prevents me from lifting heavy weights off the floor, but I can
manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4-READING

A. I can read as much as I want to, with no pain in my neck.
B. I can read as much as I want to, with slight pain in my neck.
C. I can read as much as I want to, with moderate pain in my neck.
D. I can't read as much as I want, because of moderate pain in my
neck.
E. I can hardly read at all, because of severe pain in my neck.
F. I cannot read at all.

SECTION 5-HEADACHES

A. I have no headaches at all.
B. I have slight headaches that come infrequently.
C. I have moderate headaches that come infrequently.
D. I have moderate headaches that come frequently.
E. I have severe headaches that come frequently.
F. I have headaches almost all the time.

SECTION 6-CONCENTRATION

A. I can concentrate fully when I want to, with no difficulty.
B. I can concentrate fully when I want to, with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.

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F. I cannot concentrate at all.

SECTION 7-WORK

A. I can as much work as I want to.
B. I can do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8- DRIVING

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want, with slight pain in my neck.
C. I can drive my car as long as I want, with moderate pain in my neck.
D. I can't drive my car as long as I want, because of moderate pain in my neck.
E. I can hardly drive at all, because of severe pain in m y neck.
F. I can't drive my car at all.

SECTION 9-SLEEPING

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr sleepless)
C. My sleep is mildly disturbed (1-2 hrs sleepless).
D. My sleep is moderately disturbed (2-3 hrs sleepless).
E. My sleep is greatly disturbed (3-5 hrs sleepless).
F. My sleep is completely disturbed (5-7 hrs sleepless).

SECTION 10-RECREATION

A. I am able to engage in all my recreation activities, with no neck pain at all.
B. I am able to engage in all my recreation activities, with some neck pain.
C. I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
D. I am able to engage in a few of my recreation activities, because of pain in my neck
E. I can hardly do any recreation activities, because of pain in my neck.
F. I can't do any recreation activities at all.

Patients Signature ________________________________ Date __________

Instructions:

1. The NDI is scored in the same way as the Oswestry Disability Index.
2. Using this system, a score of 10-25% (i.e., 5-14 points) is considered by the authors to constitute mild disability; 30-40% is moderate; 50-68% is severe; 72% or more is complex.

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Disability Index Score

Section 1—Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

Section 2—Personal Care
A. I would not have to change my way of washing or dressing in
order to avoid pain.
B. I do not normally change my way of washing or dressing even
though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to
change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary
to change my way of doing it.
E. Because of the pain, I am unable to do some washing and
dressing without help.
F. Because of the pain, I am unable to do any washing and
dressing without help.

Section 3—Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I
can manage if they are conveniently positioned, e.g. on a table
E. Pain prevents me from lifting heavy weights off the floor, but I
can manage light to medium weights if they are conveniently
positioned.
F. I can only lift very light weights, at the most.

Section 4—Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than 1/2 mile.
D. Pain prevents me from walking more than 1/4 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

Section 5—Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

Section 6—Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with
time.
C. I cannot stand for longer than one hour without increasing
pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing
pain.
F. I avoid standing because it immediately increases the pain.

Section 7—Sleeping
A. I get no pain in bed.
B. I get some pain in bed, but it does not prevent me from
sleeping well.
C. Because of pain, my normal night's sleep is reduced by less
than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less
than one-half.
E. Because of pain, my normal night's sleep is reduced by less
than three-quarters.
F. Pain prevents me from sleeping at all.

Section 8—Social Life
A. My social life is normal and gives me no pain.
B. My social life is normal, but increases my degree of pain.
C. Pain has no significant effect on my social life apart from
limiting my more energetic interactions, e.g. dancing, etc.
D. Pain has restricted my social life and I do not go out very
often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

Section 9—Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of
travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to
seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek
alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

Section 10—Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow
at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening

Patients Signature ________________________________ Date __________
Disability Index Score % ___________

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INFORMED CONSENT FOR TREATMENT

PATIENT NAME ________________________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use
my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click,"
much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/ Examination/ Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
__spinal manipulation therapy __palpation __vital signs
__range of motion testing __orthopedic testing __basic neurological testing
__muscle strength testing __postural analysis __EMS
__radiographic studies __hot-cold therapy __other (please explain)
____
____

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest,
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers,
- Hospitalization,
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the information of adhesions and reduce mobility when may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Casey A. Conran and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: ______ Patient's Name _________________ Patient's signature _________________

Date: ______ Signature of Parent or Guardian (if a minor) ___________________________

Date: ______ Doctor's Name: Casey A. Conran, D.C. Doctor's Signature: ______________

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Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning Case Chiropractic's patient financial policy.

Prompt payment, allows us to control costs. Outstanding accounts cost both of us time and money: therefore, all patients will be required to establish financial arrangements for payment of their accounts.

Worker's compensation patients As long as your care is determined to be W/C there is no financial responsibility due from you. However, if your claim is controverted or denied the balance will be your responsibility and the financial policy will apply to your account.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. As a courtesy our practice will bill your insurance carrier. After 90 days It will then be your responsibility to remit payment for any unpaid claims by your carrier as well as any and all charges not covered by your carrier.

All copays, deductibles, and patient co-insurances are due at the time of service.

Our office does accept third party liability, however, if the third party insurance does not pay it is the patient's responsibility.

If your carrier requires Authorization our office will be happy to assist you in this process however, ultimately this is your responsibility.

Each month you will receive a monthly statement for services which are due and payable within 10 days.

All patients refusing to remit payment after the 10 days have passed; will force us to limit their future credit until the previous balance is paid in full. All patients will be required to sign a written legal agreement with our practice. All accounts are subject to be forwarded to a collection agency and credit bureau as well as all additional costs occurred in collecting the debt.

All returned check for non-sufficient funds will be subjected to a $40.00 fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort available to you to clarify any misunderstandings you have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services.

If you have any questions concerning our policy or need assistance, please contact us immediately.

______________________________ ________________________
Patient's Name Date

______________________________ ________________________
Guardian Signature Date

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WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.
2. If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.
5. Unless indicated by the doctor, you may return to work/school after your appointment.
6. If you experience pain between scheduled visits, contact the clinic at 580-357-8688 during office hours.

I have read and understand the instructions given for my follow-up care.

Name of Patient ____ Date ______________
Patient's Signature ______________________________________ Date ______________