DR. MICHAEL A. RIHN
DR. TERESA FLETCHER RIHN
13667 Bandera Rd.
Helotes, TX 78023

(210) 695-5557
FAX (210) 695-5553
EMAIL:
HELOTESCHIRO@GMAIL.COM

HELOTES CHIROPRACTIC CLINIC

Case History

Today's Date: ____________________

Patient Name: ____________________ Birth Date: ____________ Age: ________

Address: ____________________ Social Security: ____________ Sex: ☐ M / ☐ F

City: ____________ State: ________ Zip: ________ Driver's License#: ____________

Home Phone: ____________ Cell Phone: ____________ Work Phone ____________

Referred to this office by: ____________________ Email Address: ____________

Employer: ____________ Occupation: ____________ ☐ Full/ ☐ Part-time

Marital Status: ____________ Spouse's Name: ____________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Multiple Races ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

Are we billing: You ___ Insurance ___Other ____________ Insurance Provider: ____________

Insured Person's Name: ____________________ Insured Person's Date of Birth: ____________

Primary Care Physician: ____________________ Date of Last Visit: ____________

Emergency Contact Person: ____________________ Phone Number: ____________

Current Health History

Give a brief description of your complaint: ____________________

____

____

____

____

____

When did this problem start? ____________

Have you ever had this problem before? ____________

If yes, when?____________

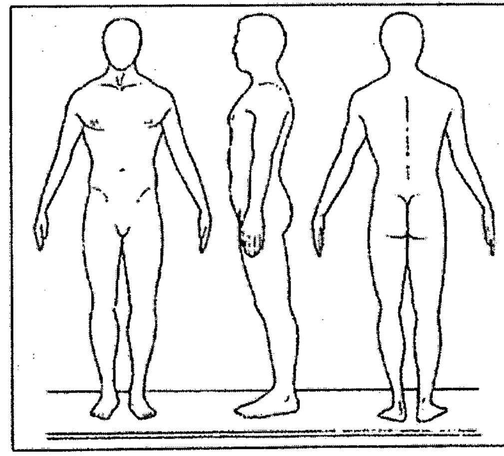
Is this problem related to: ___Car Accident ___ Work Accident

___ Other Accident ___ No Accident or Injury

If Accident, Date: ____________ Time: ____________

Have you reported the accident? ____________

Please mark the areas of complaint on the diagram below:



Rate your pain **from 0 (no pain) to 10 (Worst pain ever)**
Circle one

0------1------2------3------4------5------6------7------8------9------10

Have you seen anyone else for this problem? ______ If yes, who? ____________________

Type of Treatment: ____________________ Results: ____________________

Have you had any X-Rays, MRI's or CT Scans for this or any other spine or head condition? ______ If yes, when? ________________

Results: ____

Modifying Factors:

Symptoms Better With: ☐ nothing helps ☐ applying cold ☐ applying heat ☐ OTC meds ☐ RX meds
☐ activity ☐ massage ☐ rest ☐ stretching ☐ sitting
☐ standing ☐ twisting ☐ walking ☐ other: ________________

Daily Actvities: Effects of Current Condition on Performance:

Bending:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Changing Positions:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Climbing Stairs:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Driving:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Household Chores:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Kneeling:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Lifting Children:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Lifting:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Self-Care:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
• Bathing:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
• Dressing:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
• Shaving:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Sexual Activity:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Sleep:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Static Sitting:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Static Standing:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Walking:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
Yard Work:	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)

Recreational Activity: Effects of Current Condition on Performance:

________________	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)
________________	☐ **No Effect**	☐ **Mild** Pain (Can do)	☐ **Moderate** Pain (Limited)	☐ **Severe** Pain (Unable to Perform)

Condition's Effect on Job Performance:

☐ **No Effect** ☐ **Mild** Pain (Can do) ☐ **Moderate** Pain (Limited) ☐ **Severe** Pain (Unable to Perform)

Current medications you are taking: ☐ Blood Pressure ☐ Cholesterol ☐ Diabetes ☐ Heart ☐ Muscle Relaxers ☐ Anti-Inflammatory
☐ Pain Killers ☐ Nerve Pills ☐ Anti-Depressants ☐ Allergy Medications ☐ Non-Prescription Medicines ☐ Supplements ☐ Other

Please list names of medications marked above: ____

____

Do you currently use or wear any of the following? ☐ Arch Supports ☐ Innersoles ☐ Orthotics ☐ Heel Lifts ☐ Back Braces/Support

☐ Other Braces or Support, Type: ________________ ☐ Other Devices, Explain: ________________

Below is a list of illnesses which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Nervous:

☐ NONE ☐ Dizziness ☐ Facial Weakness ☐ Headache ☐ Limb Weakness ☐ Loss of Memory ☐ Loss of Consciousness

☐ Numbness ☐ Sleep Disturbance ☐ Seizures ☐ Slurred Speech ☐ Stress ☐ Stroke ☐ Tremors ☐ Unsteadiness

Allergy:

☐ NONE ☐ Sneezing ☐ Food Intolerance ☐ Itching ☐ Sinus Pressure ☐ Nasal Congestion

Illnesses:

☐ NONE ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Congestive Heart Failure ☐ Depression

☐ Diabetes ☐ Eye Problems ☐ Hepatitis ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Kidney Disease

☐ Seizures ☐ Liver Disease ☐ Thyroid ☐ Lung Disease ☐ Shingles (Chicken Pox) ☐ Eczema

☐ Psychological Problems

FEMALES: OB/GUN Problems: ______________________________

☐ NONE ______________________________

Past Health History

Surgeries: Type: ______________________ When: ____________

☐ NONE Type: ______________________ When: ____________

Type: ______________________ When: ____________

Injuries/Falls/Accidents(Describe what & When): ______________________________

☐ NONE ______________________________

____

____

Habits:

☐ Smoking Packs/Day ________

☐ Drinking Alcohol ________

☐ Coffee Cups/Day ________

Exercise:

☐ NONE

☐ Moderate, Type: ______________________

☐ Daily, Type: ______________________

Family History

	Alive	Deceased	Condition(s)
Father	☐	☐	______________________
Mother	☐	☐	______________________
Brother(s) #____	☐	☐	______________________
Sister(s) # ____	☐	☐	______________________

DR. MICHAEL A. RIHN
DR. TERESA FLETCHER RIHN
13667 Bandera Rd.
Helotes, TX 78023

HELOTES CHIROPRACTIC CLINIC

(210) 695-5557
FAX (210) 695-5553
EMAIL:
HELOTESCHIRO@GMAIL.COM

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns Drs. Rihn and their staff the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with **Article 21.55** of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above **within 60 days** following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which 1/we personally owe which are not payable under the terms of the policy. This demand specifically conforms to **Article 21.55** of the Texas Insurance Code, providing for attorney fees, **18% penalty,** court costs, and interest from judgment, upon violation.

THIRD PARTY LIABILITY: If my injuries are the results of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered, payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic office, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as original.

Patient Signature Date

DR. MICHAEL A. RIHN
DR. TERESA FLETCHER RIHN
13667 Bandera Rd.
Helotes, TX 78023

(210) 695-5557
FAX (210) 695-5553
EMAIL: HELOTESCHIRO@GMAIL.COM

HELOTES CHIROPRACTIC CLINIC

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr.'s Rihn (and whomever he/she may designate as his/her assistants) to administer treatments as necessary, and to perform therapy, manipulation and procedures that are considered therapeutically 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 Treatment, the reasons why the treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr.'s Rihn.

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

Printed Name: ______________________________ Date: ______________________

Signature: ______________________________ Relationship to Patient: ______________

Witness: ______________________________ Date: ______________________

Consent to X-RAY

I hereby authorize Dr.'s Rihn and whomever he/she designates as his/her assistant(s) to take x-rays of myself or said minor.

Printed Name: ______________________________ Date: ______________________

Signature: ______________________________ Relationship to Patient: ______________

Witness: ______________________________ Date: ______________________

CONSENT TO X-RAY

Pregnancy Release

* Must be completed for all females of childbearing age and signed in the patient's own handwriting, (or parent's/guardians).

Date of onset of patient's last menstrual period (LMP): ______________________________

I hereby release Dr.'s Rihn and whomever he/she designates as his/her assistant(s) from any and all liability.

Printed Name: ______________________________ Date: ______________________

Signature: ______________________________ Relationship to Patient: ______________

Witness: ______________________________ Date: ______________________

DR. MICHAEL A. RIHN
DR. TERESA FLETCHER RIHN
13667 Bandera Rd.
Helotes, TX 78023

HELOTES CHIROPRACTIC CLINIC

(210) 695-5557
FAX (210) 695-5553
EMAIL: HELOTESCHIRO@GMAIL.COM

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _______day of _______________ 20_______.

Print Patient Name ____

Signature ____

Relationship to Patient ______________________________