CASE HISTORY

Date_______________________

Name_______________________ Home Phone*_______________________
Address*_______________________ Work Phone*_______________________
City, State, Zip_______________________ Cell Phone*_______________________
Birth Date_______________ Age__________ E-mail Address*_______________________
Occupation_______________________ Employer_______________________
Social Security Number_______________________ Marital Status M S W D
Spouse's Name_______________________ # of Children_______________________
How were you referred to our office?_______________________
Have you ever had Chiropractic Care before?__________If yes, when?__________Results?__________

*By disclosing this information I allow Tickel Chiropractic to communicate with me via these means.

List your chief complaints in order of severity:

1. _______________________ For how long?_______________________
2. _______________________ For how long?_______________________
3. _______________________ For how long?_______________________

♦Auto and work-related injuries can cause serious spinal problems. Is this visit related to an accident or injury?
□ Yes □ No Date of incident:_______________________
♦If the doctor feels that chiropractic will help you, are you willing to follow his/her recommendations? □ Yes □ No
●Would you like to receive our weekly newsletter via email? □ Yes □ No

Please enter: 1 (Previously); 2 (Presently) in front of all of the following signs and symptoms. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS
___Headache
___Dizziness
___Convulsions
___Loss of Sleep
___Fatigue
___Loss of Weight
___Numbness or Pain in arms/legs/hands
___Allergy (What?)
__Other____________

MUSCLE & JOINTS
___Weakness
___Stiff Neck
___Backache
___Swollen Joints
___Tremors
___Foot Trouble
___Pain between Shoulders
___Hernia
___Spinal Curvature

GASTRO-INTESTINAL
___Poor Digestion
___Belching or Gas
___Nausea
___Pain Over Stomach
___Constipation
___Diarrhea
___Colon Trouble
___Hemorrhoids (Piles)
__Other____________

CARDIO-VASCULAR
___Slow Heart
___High Blood Pressure
___Low Blood Pressure
___Swelling of Ankles
___Poor Circulation
___Varicose Veins
___Strokes
___Blood Type A B O AB
__Other____________

EYE EAR NOSE THROAT
___Poor Vision
___Deafness
___Ear Noises
___Nose Bleeds
___Sore Throat
___Asthma
___Frequent Colds
___Sinus Trouble
__Other____________

SKIN OR ALLERGIES
___Bruise Easily
___Dryness
___Sensitive Skin
___Hives or Allergy
___Eczema
__Other____________

RESPIRATORY
___Chronic Cough
___Spitting Blood
___Spitting Phlegm
___Difficulty Breathing
__Other____________

FOR WOMEN ONLY
___Painful Periods
___Excessive Flow
___Irregular Cycles
___Hot Flashes
___Cramps or Backache
___Miscarriage
___Vaginal Discharge
___Pregnant at this time
___Last Pap?__________

Other____________________
____

GENITO-URINARY
___Frequent Urination
___Painful Urination
___Blood in Urine
___Kidney Infection
___Bed Wetting
___Inability to Control Urine
___Prostate Trouble
___Other____________

HABITS
___Smoking __Pks/day
___Alcohol __Per day
___Coffee __Cups/day

EXERCISE
___None
___Moderate
___Daily

FAMILY HISTORY:	Heart	Diabetes	Kidney	Cancer	Stroke	Back	Osteoporosis
Mother	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Father	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Brother No. of____.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Sister No. of____.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

HAVE YOU HAD ANY OF THE FOLLOWING:

___Alcoholism ___Cancer ___Epilepsy ___Lumbago ___Pleurisy ___Tuberculosis
___Anemia ___Chicken Pox ___Goiter ___Measles ___Pneumonia ___Venereal Disease
___Appendicitis ___Diabetes ___Heart Disease ___Mental Disorder ___Polio ___Whooping Cough
___Arthritis ___Eczema ___Influenza ___Mumps ___Rheumatic Fever

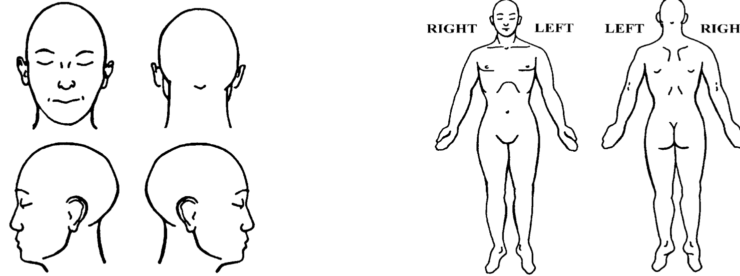
OPERATIONS AND PROCEDURES:

Procedure	Year
Appendectomy	
Back Operation	
Breast	
Gall Bladder	
Hernia	

Procedure	Year
Ovary/Uterus	
Prostate	
Rectal Surgery	
Sinus	
Stomach	

Procedure	Year
Thyroid	
Tubes in Ears	
Vaccinations	
Other	
Other	

Please indicate on the following chart areas of your body where you have pain or discomfort.



ACCIDENTS OR FALLS: Auto, etc.:____

BROKEN BONES OR DISLOCATIONS:____

Have you ever had a spinal tap or spinal injection? Yes____ No____ Have you ever been knocked unconscious? Yes____ No______

Do you suffer from any condition other than that for which you are now consulting us? Yes ____ No ____. If so, what is that condition?____

If you are presently taking any medication, either prescription or over-the-counter, list them and their dosages:____________________

____

Are you presently, or have you ever been involved in a malpractice suit of any type? Yes ___ No____. If so, please explain briefly:

____

Do you have any type of health insurance?________________ Company?______________________________

Phone#______________________________ Policy #______________________________

"I understand and agree that the clinic does not bill patients for care, and patients are expected to pay for their services on the day that they are rendered unless other arrangements have been made prior to care. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. The clinic's policy is to recommend what is best for each patient. What an insurance company may or may not pay is between the patient and the patient's insurance company, and the clinic will not and cannot set its recommendations by what an insurance company's particular policy may be. I believe that it is my constitutional right to accept or reject any treatment or examination offered to me whether it is considered "orthodox or unorthodox, medically necessary or unnecessary, investigational or experimental".

I authorize my insurance company to send payments directly to Tickel Chiropractic. I agree that if an insurance check comes to me, I will bring it or mail it immediately to Tickel Chiropractic. Any amount authorized to be paid directly to the Tickel Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that if any amount on my account is 30 days or older, a 1% per month finance charge will be added to that balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he deems appropriate and to release information to my insurance company. The Doctor has my permission to contact other health care providers that may be involved in my health care. It is understood and agreed that the x-ray negatives made of me will remain the property of the Doctor's Office and copies of said negatives, as well as other records, will be made for me or my designate at a nominal charge, if so requested. I (the patient) also agree that I am responsible for all bills incurred at this office.

I swear that I have not engaged the services of the Doctor for any hidden purposes, "state or federal harassment or the filing of a malpractice suit". The Doctor will not be held responsible for any pre-existing condition, nor for any diagnosis that he has not made. Finally, I understand that the program may consist of chiropractic, physical therapy, other alternative health care methods, and metabolic and nutritional guidance. I have the right to reject this care at any time and I have not been advised against any medical examination and/or treatment."

*Patient's Signature:*____*Date:*____________________

MINOR PATIENT ONLY: By signing below, I, the parent or guardian of the above named patient, give Drs. Will & Tammy Tickel permission to examine and/or treat my minor child.

*Parent/Guardian Signature:*____*Date:*____________________

Tickel Chiropractic Office

Drs. Will & Tammy Tickel * Phone: (218) 284-3030
819 30th Ave, #100
Moorhead, MN * 56560

Patient's Name____ **Date:**____________________

*[Please **circle the number** which most closely describes your chief complaint(s) today:*

1. Pain Intensity

(0)	(1)	(2)	(3)	(4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency Of Pain

(0)	(1)	(2)	(3)	(4)
No Pain	Occasional Pain 25% Of The Day	Intermittent Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to move slowly	Moderate Pain Need some assistance	Severe Pain Need 100% Assistance

4. Travel (Driving, Riding, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

(0)	(1)	(2)	(3)	(4)
Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

(0)	(1)	(2)	(3)	(4)
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Sleeping

(0)	(1)	(2)	(3)	(4)
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

(0)	(1)	(2)	(3)	(4)
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Mod Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

(0)	(1)	(2)	(3)	(4)
No Pain Any distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing

11. Sitting

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Sitting

Tickel Chiropractic
819 30th Ave S, #100
Moorhead, MN 56560
(218) 284-3030

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

TO LOCATE, ANALYZE, AND CORRECT
SPINAL INTERFERENCE TO THE NERVOUS SYSTEM.

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S)
OTHER THAN VERTEBRAL SUBLUXATIONS.

WE OFFER NO TREATMENT OF CONDITION(S) OR DISEASE(S)
OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

THE CHIROPRACTIC ADJUSTMENT RESTORES
LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!

I, ___________________________________, having read the above statement, and understanding it fully, do undertake chiropractic health care on this basis.

DATE:____

SIGNATURE:_____________________________________

NOTICE OF PRIVACY PRACTICES

Drs. Will & Tammy Tickel, D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, you chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule and appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share you protected health information with the third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If you chiropractor or another chiropractor in the practice is required

by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent form you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent of authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact**:** **Dr. Tammy Tickel**, Officer Manager (218) 284 – 3030 Fax (218) 284 – 3035

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Drs. Will & Tammy Tickel, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name ______________________________ Date ______________________

Signature ______________________________

Printed Name of Parent/Guardian ______________________________

Signature of Parent/Guardian ______________________________