

# Goulet Family Chiropractic Confidential Patient Case History

Name \_\_\_\_\_ Last 4# of SSN \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Number of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Referred By \_\_\_\_\_

Please check any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

**GENERAL**

- Allergies
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of Sleep
- Nervousness/Depression
- Numbness

**CARDIO-VASCULAR**

- Heart Disease
- High Blood Pressure
- Low Blood Pressure
- Pain Over Heart
- Poor Circulation

**EYES,EARS,NOSE & THROAT**

- Asthma
- Colds
- Earache
- Ear Noises
- Eye Pain
- Failing Vision
- Nosebleeds
- Sinus Infection
- Sore Throat

**MUSCLE & JOINT**

- Arthritis
- Foot Trouble
- Low Back Pain
- Neck pain or stiffness
- Spinal Curvature

**PAIN OR NUMBNESS IN**

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Tailbone
- Sciatica

**GASTRO-INTESTINAL**

- Constipation
- Diarrhea
- Gall Bladder Trouble
- Hemorrhoids
- Nausea
- Pain Over Stomach
- Poor Appetite
- Vomiting

**RESPIRATORY**

- Chest Pain
- Chronic Cough
- Difficult Breathing
- Spitting Up Blood
- Spitting Up Phlegm
- Wheezing

**GENTIO-URINARY**

- Bed Wetting
- Blood in Urine
- Frequent Urination
- Inability to Control Kidneys
- Kidney Infection or Stones
- Painful Urination
- Prostate Trouble

**FOR WOMEN ONLY**

- Cramps or Backache
  - Hot Flashes
  - Irregular Cycle
  - Menopausal Symptoms
  - Painful Menstruation
- Are you pregnant? Yes or No

Check the following conditions you have had:

- |   |                                    |   |   |   |
|---|------------------------------------|---|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever    |   |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Stroke           |   |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Tuberculosis     |   |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Ulcers           |   |
| <input type="checkbox"/> Cold Sores       | <input type="checkbox"/> Measles   | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal Disease |   |

Habits: Heavy (H) Moderate (M) Light (L) None (N)

\_\_\_ Alcohol    \_\_\_ Coffee    \_\_\_ Tobacco    \_\_\_ Drugs    \_\_\_ Exercise

In Case of Emergency: Name/Relation \_\_\_\_\_ Phone \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

Other complaints? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Circle any that apply: 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 felt good? \_\_\_\_\_

Place an X on the line below to indicate level of problem

*No Symptoms* \_\_\_\_\_ *Extreme Symptoms*

List previous diagnosis and treatment you have received for present condition \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

List surgical operations and year performed. \_\_\_\_\_

Drugs you presently take: \_\_\_\_\_

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

Have you been in an auto accident? Past Year Past Five Years Over Five Years Never

Have you ever had any mental or emotional disorders? Yes No When? \_\_\_\_\_

Family Health Information (many health problems are the result of hereditary spinal weaknesses; therefore information about your family members will give us a better picture of your total health picture)

NAME RELATION PAST AND PRESENT HEALTH PROBLEMS

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

Have you ever been knocked unconscious? YES NO Have you ever fractured a bone? YES NO

Do you take vitamin or mineral supplements? \_\_\_\_\_ What kind? \_\_\_\_\_

Name of primary physician? \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

I have been given a copy of the Patient Health Information Privacy Notice

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Goulet Family Chiropractic

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning these records. Before we began any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your **PHI**, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their **PHI** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested **PHI** to the Health Insurance Company (or companies) provided to us by the patient, for the purpose of payment. Be assured that this office will limit the release of all **PHI** to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their **PHI**. Our office is not obligated to agree with those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are know by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (**PHI**) will be used and I agree to these policies and procedures.

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Print Patient Name

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Patient / Guardian Signature

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Date

**Please Complete Back Side**

## GOULET FAMILY CHIROPRACTIC

<b>Fee Schedule -</b>	Initial Exam/Consultation	\$40.00 - \$70.00
	Cervical X-Rays (3 views)	\$50.00
	Thoracic X-Rays (2 views)	\$50.00
	Lumbar X-Rays (2 views)	\$50.00
	Regular Adjustment	\$45.00
	Medicare Adjustment	\$25.00
	Active Military Adjustment	\$25.00

**Patients Without Insurance** - It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. We accept cash, your personal check, MasterCard and Visa cards.

**Group Or Individual Insurance** - Benefits quoted to us by your insurance company are not a guarantee of payment. At time of service, you are responsible for any non-covered services, deductibles or co-pays. We will file your claim and wait payment for 90 days. You will be responsible for any charges not paid by your insurance company. Please inform us of any secondary insurance you might have.

**Medicare** - If primary insurance is Medicare, we do not accept assignment from Medicare. You are responsible for total payment of services rendered at the time of service - for example the cost of initial examination, x-rays and/or adjustment. We file your charges with Medicare for you. Medicare, in return, reimburses you for a portion of the adjustment cost only, once your deductible is met. Medicare will forward your claim to your secondary insurance company for you.

**Personal Injury Or Automobile Accidents** - Please notify us immediately if this is an accident claim and if an attorney is representing you. Also notify your auto insurance carrier immediately of your visit to our office. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

**Worker's Compensation- (WC)** - Notify us immediately if this is a WC claim. If you are injured on the job, your care should be paid for under your employer's WC insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance for our office. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

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**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:** I authorize the release of any medical or other information necessary to process my claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment.

**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:** I understand and accept the fee schedule listed above. I authorize payment of medical benefits to Dr. Gary M. Goulet and Dr. Jeremy M. Goulet for services provided.

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**Signature**

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**Date**

**Goulet Family Chiropractic  
Terms of Acceptance**

When a patient seeks chiropractic care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal – to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understands both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

**Adjustment:** The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

**Health:** A state of *Optimal* physical, mental and social well-being; not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnosis or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

**OUR ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Female Patient Pregnancy Release**

This is to certify that to the best of my knowledge, I am not pregnant. The above referenced doctors have my permission to preform an x-ray evaluation, if necessary. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Consent to Evaluate and Adjust a Minor Child**

I, \_\_\_\_\_, being a parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date