

Chiropractic Case History/Patient Information

Date: _____ **Patient #** _____ **Doctor:** _____

Name: _____ **Social Security #** _____ **Home Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-mail address: _____ **Fax #** _____ **Cell Phone:** _____

Age: _____ **Birth Date:** _____ **Race:** _____ **Marital:** M S W D

Occupation: _____ **Employer:** _____

Employer's Address: _____ **Office Phone:** _____

Spouse: _____ **Occupation:** _____ **Employer:** _____

How many dependents? _____ **Names and Ages:** _____

Name of Nearest Relative: _____ **Address:** _____ **Phone:** _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
 Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. 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.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. 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. **The following person(s) have my permission to receive my personal health information:**

Patient's Signature: _____ **Date:** _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

PATIENT NAME _____

DATE _____

Doctor _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work___ Other_____

Have you ever had the same or a similar condition? π Yes π No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? π Yes π No

If yes, describe: _____

Do you have any allergies of any kind? π Yes π No

If yes, describe: _____

Do you have any Congenital Condition? ___ Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **C** if you are **currently** experiencing these conditions or **P** if you have had these conditions **previously**.

N = Now

P = Previously

Headaches _____ Frequency _____
 Neck Pain _____
 Stiff Neck _____
 Sleeping Problems _____
 Back Pain _____
 Nervousness _____
 Tension _____
 Irritability _____
 Chest Pains/Tightness _____
 Dizziness _____

Loss of Balance _____
 Fainting _____
 Loss of Smell _____
 Loss of Taste _____
 Unusual Bowel Patterns _____
 Feet Cold _____
 Hands Cold _____
 Arthritis _____
 Muscle Spasms _____
 Frequent Colds _____

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PATIENT NAME _____

DATE _____

Doctor _____

- | | | | |
|-------------------------|-------|------------------------|-------|
| Shoulder/Neck/Arm Pain | _____ | Fever | _____ |
| Numbness in Fingers | _____ | Sinus Problems | _____ |
| Numbness in Toes | _____ | Diabetes | _____ |
| High Blood Pressure | _____ | Indigestion Problems | _____ |
| Difficulty Urinating | _____ | Joint Pain/Swelling | _____ |
| Weakness in Extremities | _____ | Menstrual Difficulties | _____ |
| Breathing Problems | _____ | Weight Loss/Gain | _____ |
| Fatigue | _____ | Depression | _____ |
| Lights Bother Eyes | _____ | Loss of Memory | _____ |
| Ears Ring | _____ | Buzzing in Ears | _____ |
| Broken Bones/Fractures | _____ | Circulation Problems | _____ |
| Rheumatoid Arthritis | _____ | Seizures/Epilepsy | _____ |
| Excessive Bleeding | _____ | Low Blood Pressure | _____ |
| Osteoarthritis | _____ | Osteoporosis | _____ |
| Pacemaker | _____ | Heart Disease | _____ |
| Stroke | _____ | Cancer | _____ |
| Ruptures | _____ | Coughing Blood | _____ |
| Eating Disorder | _____ | Alcoholism | _____ |
| Drug Addiction | _____ | HIV Positive | _____ |
| Gall Bladder Problems | _____ | Depression | _____ |
| Ulcers | _____ | | |

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

- | | | |
|-------------------------|-----------------------------|------------------------------|
| _____ Vigorous Exercise | _____ Caffeine | _____ Other (Please Specify) |
| _____ Moderate Exercise | _____ High Stress Activity | _____ |
| _____ Alcohol Use | _____ Family Pressures | _____ |
| _____ Drug Use | _____ Financial Pressures | |
| _____ Tobacco Use | _____ Other Mental Stresses | |

TIME PREFERENCES

Please indicate which times would be best for you to schedule future appointments. Mark all possible times that fit your schedule

	Mon	Tues	Wed	Thurs	Fri
10:00 - 11:00					
11:00 - 12:00					
12:00 - 1:00					
1:00 - 2:00	-----	-----	-----	-----	
2:00 - 3:00					-----
3:00 - 4:00					-----
4:00 - 5:00					-----
5:00 - 6:00					-----

PATIENT NAME _____

DATE _____

Doctor _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age []	MOTHER Age []	SPOUSE Age []	BROTHER(S) Age [] Age []	SISTERS Age [] Age []	CHILDREN Age [] Age []
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____