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 children?_____Names and Ages of Children:_____

_____

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:_____

Mechanism of Injury: Auto___ Work____ Other_____

What makes the symptoms feel better?_____

What makes the symptoms feel worse?_____

What does the discomfort feel like?_____

Does the discomfort radiate to another area?_____

How do you rate your pain on a scale of 0-10 (0=No Pain, 10=Most Severe)_____

Is the pain worse at any time of the day?_____

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

_____

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

Have you had any recent hospitalizations, injuries, infections, or trauma? Women, please include information about childbirth (include dates): _____

_____

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

If yes, describe:_____

What medications or drugs are you taking?_____

_____

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

If yes, describe:_____

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

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If yes, Describe _____

Women: Are you pregnant? _____

PATIENT NAME _____

DATE _____ Doctor_____

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

N = Now P = Previously

Diabetes	_____	Tobacco Use	_____
High Blood Pressure/Stroke	_____	Obesity/Over Weight	_____
Cancer	_____	Chronic Pain >6 months	_____
Broken Bones/Fractures	_____	Depression	_____
Arthritis	_____	Heart Disease	_____
Sprains/Strains	_____	Pacemaker	_____
Neck Pain/Stiffness	_____	Circulation Problems	_____
Headaches_____ Frequency	_____	Fainting	_____
Shoulder Pain	_____	Loss of Balance	_____
Numbness/ Pain in Hand	_____	Loss of Smell	_____
Muscle Spasms	_____	Loss of Taste	_____
Joint Pain/Swelling	_____	Feet Cold	_____
Weakness in Extremities	_____	Hands Cold	_____
Back Pain	_____	Low Blood Pressure	_____
Hip Pain	_____	Chest Pains/Tightness	_____
Thigh Pain	_____	Dizziness	_____
Lower Leg Pain	_____	Breathing Problems	_____
Numbness/Pain in Feet	_____	Menstrual Difficulties	_____
Unusual Bowel Patterns	_____	Nervousness	_____
Difficulty Urinating	_____	Tension	_____
Osteoporosis	_____	Irritability	_____
Osteoarthritis	_____	Sinus Problems	_____
Rheumatoid Arthritis	_____	Sleeping Problems	_____
Indigestion Problems	_____	Frequent Colds	_____
Gall Bladder Problems	_____	Fever	_____
Ulcers	_____	Weight Loss/Gain	_____
Coughing Blood	_____	Fatigue	_____
Excessive Bleeding	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Eating Disorder	_____	Lights Bother Eyes	_____
Drug Addiction	_____	Seizures/Epilepsy	_____
Alcoholism	_____	HIV Positive	_____

SOCIAL HISTORY

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

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor_____

FAMILY HISTORY

Please list any diseases or illness that affected any of your immediate family members

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]

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

Surgical History

_____
_____
_____
_____
_____
_____

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____