CHIROPRACTIC CASE HISTORY / PATIENT INFORMATION

Date: _____ Patient #: _____ Doctor:_____

Name: _____ SS#: _____
Address (street, city, state, & zip): _____
Email: _____ Home #:_____
Fax #: _____ Cell # _____
Age:_____ Birth Date: _____ Marital: S M D W
Occupation:_____ Employer: _____
Employer's address: _____ Office #:_____
Spouse: _____ Occupation: _____
Spouse's employer:_____
How many children?_____ Names / Ages: _____
_____
Name of nearest relative: _____ Phone #:_____
Address: _____
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 ❒ 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 payers 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's Name:_____ Date:_____

HISTORY OF PRESENT & PAST ILLNESS:

Chief complaint (Purpose of this appointment):_____
Date symptoms appeared / accident happened: _____
Is this due to: ( ) Auto ( ) Work ( ) Other_____
Have you ever had the same or similar condition? ( ) Yes ( ) No
If yes, describe:_____
Days lost from work: _____Date of last physical exam:_____
Do you have a history of stroke or hypertension? _____
Have you had any major illnesses, injuries, falls, accidents or surgeries? Women, please include information about childbirth (include dates) _____
_____
Has a physician treated you for any health condition in the last year? ( ) Yes ( ) No
If yes, describe:_____
What medications/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 conditions? ( ) Yes ( ) No
If yes, describe:_____
Women Only: Are you pregnant? ( ) Uncertain ( ) Yes ( ) No

Have you had or 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**.

____Headaches____x/wk	____Neck Pain	____Stiff Neck
____Back Pain	____Nervousness	____Sleeping Problems
____Tension	____Fainting	____Loss of Balance
____Irritability	____Chest Pain	____Dizziness
____Loss of Smell	____Loss of Taste	____Shoulder/Arm Pain
____Feet Cold	____Hands Cold	____Numbness in Fingers
____Arthritis	____Muscle Spasms	____Numbness in Toes
____Frequent Colds	____Fever	____High Blood Pressure
____Sinus Problems	____Diabetes	____Difficulty Urinating
____Indigestion	____Joint Pain/Swelling	____Weakness (Extremities)
____Menstrual Difficulties	____Unusual Bowel Patterns	____Breathing Problems
____Fatigue	____Lights Bother Eyes	____Weight Loss/Gain
____Ears Ring	____Broken Bones	____Rheumatoid Arthritis
____Osteoarthritis	____Excessive Bleeding	____Circulation Problems
____Pacemaker	____Stroke	____Gall Bladder Problems
____Ulcers	____Drug Addiction	____Eating Disorders
____Ruptures	____Depression	____Loss of Memory
____Low Blood Pressure	____Osteoporosis	____Seizures/Epilepsy
____Buzzing in Ears	____Cancer	____HIV Positive
____Coughing Blood	____Alcoholism	____Heart Disease

Patient's Name:_____ Date:_____

SOCIAL HISTORY

please indicate beside each activity whether you engage in it:
Often = O Sometimes = S Never = N

_____ Vigorous Exercise _____ Moderate Exercise _____Caffeine
_____ Family Pressures _____ Financial Pressures _____Drug Use
_____ Other Mental Stresses _____ Tobacco Use _____Alcohol Use
_____ High Stress Activity _____ Other (specify) _____

FAMILY HISTORY

Review the listed diseases / conditions and indicate with an **X**, those that are current health problems of the family member. Leave blank those spaces that don't apply. **Circle** the answer if your relative lives around this locality, as some hereditary conditions are due to similar climate.

CONDITION	FATHER Age[ ]	MOTHER Age[ ]	SPOUSE Age[ ]	BROTHER(S) Age[ ] Age[ ]	SISTER(S) Age[ ] Age[ ]	CHILDREN Age[ ] Age[ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood 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: _____