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:___________ Marital Status: M S W D How many children?___________________
Occupation:_________________________ Employer:____
Employer's Address:__________________________________ Office Phone:____________________________
Spouse:___________________ Occupation:________________ Employer:______________________________
Emergency Contact:________________________ 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?___________

HISTORY OF PRESENT 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? ☐ Yes ☐ No If yes, when and describe:______________

____

Days lost from work:_________________ Date of last physical examination:_________________________

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions? (Check all those that apply)

__Broken Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive Bleeding
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pacemaker
__Strokes
__Cancer
__Ruptures
__Coughing Blood
__Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression
__Ulcers

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? ☐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:_______________________________

Please list any other health problems you have, no matter how insignificant they may be:____

____

SOCIAL HISTORY

Do you drink alcoholic beverages?______ If so, how much per week?___________________________________
Do you use any tobacco products?______Do you smoke?____ If so, packs per day: ________________________
Do you take vitamin supplements?________ If so, please list:____
Do you consume caffeine?____ If so, how much per day:____

Do you exercise?__________ If yes, what is the frequency and type of exercise?___________________________
What are your hobbies?____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____ working at a computer_____

FAMILY HISTORY

Parents:
Father: living___ deceased____ (check one) Current age if still living:______ Cause of death and age at death if deceased:____________________

Mother: living___ deceased____ (check one) Current age if still living:______ Cause of death and age at death if deceased:____________________

Check if applicable to you: _________ As an adopted child, little is known of birth parents or family.

FAMILY DISEASES (check if applicable and indicate whether **M**aternal/**P**aternal side or **S**ister or **B**rother):

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Cancer____
Asthma____
Kidney Disease____
Liver Disease ____
Mental Illness____
Heart Disease ____
Lung Disease____
Other ___________

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:____
(if this is an auto accident, this is the insurance co. of the car you were in)
ID or Claim Number_____________________________ Group #_______________________________________
Subscriber's Name_____________________________ Relationship to Patient___________________________
Address____ Birth Date_____________________________
(if different than patient)

Name of Secondary Insurance Company (if any):____
ID or Claim Number_____________________________ Group #_______________________________________
Subscriber's Name_____________________________ Relationship to Patient___________________________
Address____ Birth Date_____________________________
(if different than patient)

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 further authorize the release of my medical records to this office. 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. I understand that interest is charged on overdue accounts at the annual rate of 16%. We reserve the right to charge a $25.00 fee for appointments missed without 24-hours notice.

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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:_______________________________________ Date:________________

1. What is your major symptom? ____
2. What does this prevent you from doing or enjoying?_______________________________________
3. If this is a recurrence, when was the first time you noticed this problem?_____________________

How did it originally occur?____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____

If yes, when and how? ____

4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

5. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____ If yes, describe: ____

6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other ____

7. Is there anything you can do to relieve the problem? Yes ___ No ___ If yes, describe _______

   ____________________ If no, what have you tried to do that has not helped? ______________

   ____

8. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____

   Lifting _____ Twisting _____ Other ____

9. List any major accidents you have had other than those that might be mentioned above: _______

   ____

10. WOMEN ONLY: Are you pregnant, or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

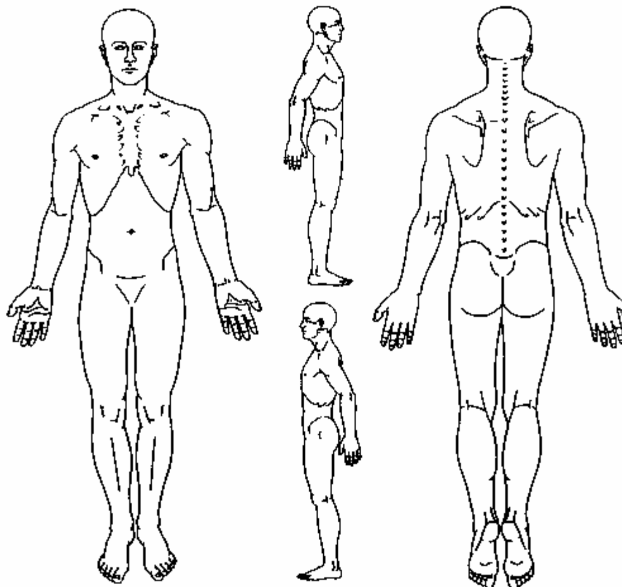
11. Remarks: ____

NO SYMPTOMS	Please place an "X" on the line above to indicate level of problem.	EXTREME SYMPTOMS

I____I

Tell Us Where You Hurt

Mark an X on the picture where you continue to have pain, numbness or tingling.



Doctor's Signature ____ Date _____________