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	__Osteoarthritis	__Eating Disorder
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pacemaker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Excessive Bleeding	__Ruptures	__Depression
__High/Low Blood Pressure	__Coughing Blood	__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____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver 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? _____

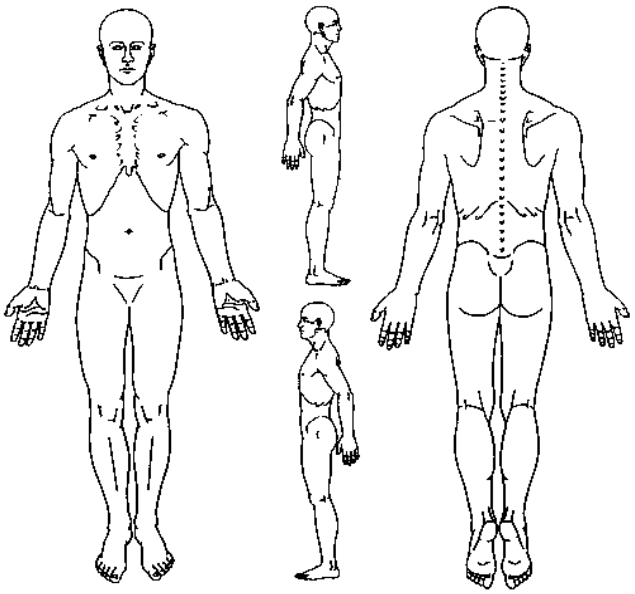
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____ If yes, describe: _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ 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 _____