



Office Use:
PIN: _____
Date of Last Adj: _____

Chiropractic Case History/Patient Information

Stephen Kutscher, D.C. & Mandi Miedema, D.C.

(719) 799-6565

Date: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

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

Occupation: _____ Name of Spouse: _____

Names/Ages Children: _____

Emergency Contact: _____ Phone: _____

How were you **referred** to our office? _____

Family Medical Doctor: _____

Address: _____

Phone: _____

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

Please circle any and all insurance/coverage options that may be applicable to your case:

Major Medical Worker's Compensation Medicare Auto Accident Medical Savings

Account & Flex Plans CareCredit Other: _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Rock Solid Chiropractic, PLLC. 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: _____

HISTORY OF PRESENT ILLNESS

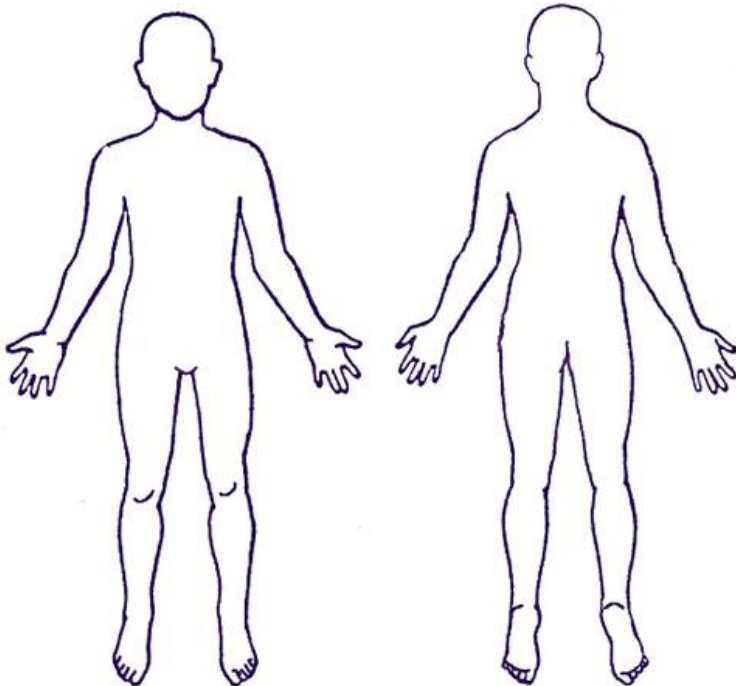
Chief Complaint(s): Purpose of this appointment: _____
 Date symptoms appeared or accident happened: _____
 Have you ever had the same or a similar condition? _____ If yes, when and describe: _____

 How did it originally occur? _____
 Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
 If yes, when and how? _____
 How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___ Morning ___
 How long does it last? All Day _____ Few Hours _____ Minutes _____
 Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___ Burning ___
 Stabbing ___ Other _____
 What relieves the problem? _____
 What aggravates the problem? _____
 What does this prevent you from doing or enjoying? _____
 Days lost from work: _____ Work Duties: _____
 Are there any other conditions or symptoms that may be related to your major symptom? Yes ___ No ___
 If yes, describe: _____

NO SYMPTOMS

EXTREME SYMPTOMS

Please place an "X" on the line above to indicate level of problem.



SUBJECTIVE PAIN ASSESSMENT

Indicate the location of your symptoms on the drawing using the following description:

- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing
- ← =Shooting or traveling

Example: ST placed between the shoulder blades indicated stabbing pain in that location.



Patient Name _____ Date _____

HEALTH HISTORY

List **ALL** major illnesses, injuries, falls, auto-accidents or surgeries over lifetime. **Doctors** determine relevance.

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

If yes, describe: _____

What medications, drugs, or supplements are you taking? For medications, list what it is being used to treat, and how long you have been taking it. _____

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? _____ Previous childbirth vaginal or cesarean _____

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

Headaches _____
Frequency _____
Location _____
Neck Pain or Stiffness _____
Back Pain or Stiffness _____
Numbness/Tingling _____
Location _____
Loss of Strength _____
Location _____
Arthritis _____
Location _____
Type _____
Bones/Fractures _____
Location _____
Joint Pain/Swelling _____
Location _____
Muscle Spasms _____
Location _____

Frequent Colds _____
Type _____
Fever _____
Fatigue _____
Reason _____
Weight Loss or Gain (circle) _____
Amount _____
Timeframe _____
Diabetes _____
Osteopenia or Osteoporosis (circle) _____
Cancer _____
Type _____
Treatment _____
HIV Positive _____

Sleeping Problems _____
Due to: pain or busy mind (circle) _____
Nervousness _____
Cause _____
Tension _____
Cause _____
Irritability _____
Cause _____
Depression _____
Cause _____
Loss of Memory _____
Loss of Balance _____
Dizziness _____
Fainting _____
Seizures _____
Ears Ring or Buzz _____
Loss of Taste _____
Loss of Smell _____
Trouble with Eyes _____
Describe _____
Eating Disorder _____
Type _____
Drug Addiction _____
Alcoholism _____

Heart Disease _____
High Blood Pressure _____
Low Blood Pressure _____
Chest Pain/ Tightness _____
Shoulder/Arm/Neck pain _____
Circulation Problems _____
Hands/Feet Cold _____
Excessive Bleeding _____
Stroke _____
Pacemaker _____

Indigestion _____
Ruptures _____
Location _____
Gall Bladder Problems _____
Ulcers _____
Unusual Bowel Patterns _____
Frequency _____
Consistency _____

Doctor's Notes:



Patient Name _____ Date _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Vigorous Exercise _____	High Stress Activity _____
Moderate Exercise _____	Family Pressures _____
Type _____	Financial Pressures _____
Alcohol Use: _____	Other Mental Stress _____
Drug Use: _____	Other (specify) _____
Tobacco Use: _____	
Caffeine Use: _____	

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						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						
Age/cause of death:						

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

Signature of Patient/Legal Guardian _____ Date _____