Chiropractic Case History/Patient Information

Date_____________ Patient #____________________ Doctor______________

Name:_________________________ Age:_____ Date of Birth:___________ Marital: M S W D

Address:________________________ City:______________ State:_____ ZIP:______________

E-mail:_________________________ Cell #:_____________ Home #:____________ # of Kids:___

Occupation:______________________________ Employer:_________________________________

Employer Address:_______________________________ Office Phone:________________________

Insured's Name:_____________________ Insured's DOB:__________ Insured's Employer:__________

Name of Nearest Relative and Phone #:____

How were you referred to our office:___________________________ Family MD:________________

Purpose of this Appointment:____

Date Symptoms appeared/accident happened:____________ Have you had this before: Yes No

Days lost form work:_____________ Date of last physical:_________ Findings:________________

____

Serious Illnesses:____

Have you been treated for any health conditions in the last year: Yes No Please Describe:__________

____

Medications/Supplements currently taking:____

____

Please circle any/all insurance coverage that may be applicable:

Major Medical	Worker's Compensation	Medicaid
Medicare	Auto Accident	Other:___________________________

Name of Primary Insurance:____

Name of Secondary Insurance (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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

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. Rate your symptoms:

____

0 1 2 3 4 5 6 7 8 9 10

NO PAIN MILD PAIN MODERATE PAIN SEVERE PAIN

3. What does this prevent you from doing?____

4. When did you first notice this problem and what were you doing?__________________________

5. Has it become worse? YES NO Same Better Gradually Worse

6. How frequent is the condition (please circle all that apply)?

   Constant Daily Intermittent Night Only

7. Are there any other conditions that may be related to you major symptom? YES NO

   a. If YES please describe:____

8. Are there any other UNRELATED health problems? YES NO

   a. If YES please describe:____

9. Describe the pain (circle all that apply):

   Sharp Dull Achey Numbness Tingling

   Burning Stabbing Other:____

10. Is there anything you can do to RELIEVE the problem: YES NO

    a. If YES please describe:____

    b. If NO what have tried that has not worked:_____________________________________

11. What makes the problem WORSE (circle all that apply):

    Standing Sitting Lying Bending

    Twisting Lifting Twisting Other:____________________

12. Have you had any broken bones? YES NO

    a. If YES please list and give dates:____

13. List any other major accidents:____

14. WOMEN ONLY: Are you pregnant or possibility you may be pregnant? YES NO UNCERTAIN

15. Any other comments:____

____

Doctor's Signature _______________________________________ Date _____________