Health History
Chiropractic Case History/Patient Information

In-office use: Patient #_____ Doctor_____

Please print this form from your computer. You can then sign the form and bring it with you to your first appointment. This form will not be submitted via the Internet, so security is not an issue.

Date_____

Name _____ Social Security #_____

Address_____

City_____ State_____ Zip_____ Home Phone _____

E-mail_____ Fax #_____ Cell Phone _____

Age _____ Birth Date_____ Race* _____

Marital: ✝ M ✝ S ✝ W ✝ D # of children?_____

Occupation_____ Employer _____

Employer's Address_____ Office Phone _____

Spouse Occupation_____ Employer _____

Name of Nearest Relative _____ Address _____

Phone _____ How were you referred to our office? _____

Primary Doctor_____

Date symptoms appeared or accident happened: _____

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 _____

What surgeries have you had? (include dates)_____

Serious illnesses (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? _____

Please check any and all insurance coverage that may be applicable in this case.

✝ Major Medical ✝ Worker's Compensation ✝ Medicaid ✝ Medicare ✝ Auto Accident 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 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%.

Patient's Signature_____ Date_____

Guardian's Signature Authorizing Care_____ Date _____

1. What is your major symptom? _____

2. 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? _____

3. How frequent is the condition? ✝ Constant ✝ Daily ✝ Intermittent ✝ Night Only

How long does it last? ✝ All Day ✝ Few Hours ✝ Minutes

4. Are there any other conditions or symptoms that may be related to your major symptom? ✝ Yes ✝ No

If yes, describe _____

Are there other unrelated health problems? ✝ Yes ✝ No

If yes, describe _____

5. Describe the pain: ✝ Sharp ✝ Dull ✝ Numbness ✝ Tingling ✝ Aching ✝ Burning ✝ Stabbing ✝ Other

6. 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?_____

7. What makes the problem worse? ✝ Standing ✝ Sitting ✝ Lying ✝ Bending ✝ Lifting ✝ Twisting ✝ Other

8. Have you had any broken bones? ✝ Yes ✝ No If yes, please list and give dates:_____
_____

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

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ✝ Yes ✝ No

If yes, please explain:_____
_____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ✝ Yes ✝ No ✝ Uncertain

12. Do you have any comments or further information that may assist the doctor in evaluating your condition and recommending treatment?_____
_____
_____

In-office use:

Doctor's Remarks: _____
_____
_____
_____
_____
_____
_____
_____
_____

Doctor's Signature_____ Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare____Medicaid____Champus___CampVA____
   Group Health Plan____ Other____Insured's ID Number_____
2. Patient Name:_____
3. Insured's Name (as it appears on the insurance card):_____
4. Patient's Address:_____
   City_____State_____ Zip_____Tel #_____
5. Insured's Address (if same as patient put "same"):_____
   City_____State_____ Zip_____Tel #_____
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):_____
   Other Insured's Policy or Group Number:_____
   Other Insured's Date of Birth:_____ Male_____Female_____
   Employer's Name or School Name:_____
   Insurance Plan Name or Program Name:_____
8. Is the condition we are treating related to current or previous employment? Yes____ No____
9. Is the condition we are treating related to an auto accident? Yes____ No____
10. Is the condition we are treating related to another type of accident? Yes ____ No____
11. Insured's Policy Group or FECA Number:_____
    Insured's Date of Birth:_____Male_____Female_____
    Employer Name or School Name:_____
    Insurance Plan Name or Program Name:_____
12. Is there another health benefit plan? Yes____ No____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____Date:_____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____Date:_____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___Name of Company_____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___