# DEER CREEK CHIROPRACTIC

## CONFIDENTIAL CASE HISTORY

**Date:_____**

**Name:_____ Home Phone:_____**

**Address: _____ City _____ Zip _____**

**E-Mail Address _____ Cell Phone:_____**

**Age: _____ Birth date _____ Marital Status: M S W D**

**Occupation: _____ Employer _____**

**Work Phone: _____ Can you take calls at work ? Yes No**

**Spouse Name: _____ How many Children ?_____**

**Ages of Children _____ How were you referred to our office? _____**

**Family Medical Doctor _____ Phone Number _____**

**When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office ? YES NO**

**HISTORY OF PRESENT ILLNESS:** Reviewed with Patient _____

**Chief Complaint: Purpose of this appointment: _____**

**Date Symptoms appeared or accident date: _____**

**Is this due to: ( ) Auto Accident ( ) Work Accident ( ) Other _____**

**Have you ever had the same or similar condition ? Yes No If yes, when and describe: _____**

_____

**Days lost from work: _____ Date of last physical examination: _____**

**What makes your condition worse: _____**

**What makes your condition better: _____**

**Is the pain (Circle all that apply) Constant —Aggravated by movement—Come and Go—Getting Worse—Same**

**Are you experiencing any: (Circle) Weakness—Radiating Pain—Dizziness—Nausea—Vomiting—Blurred Vision**

**Please indicate the level of pain you are currently experiencing by writing each involved body area on the scale below:**

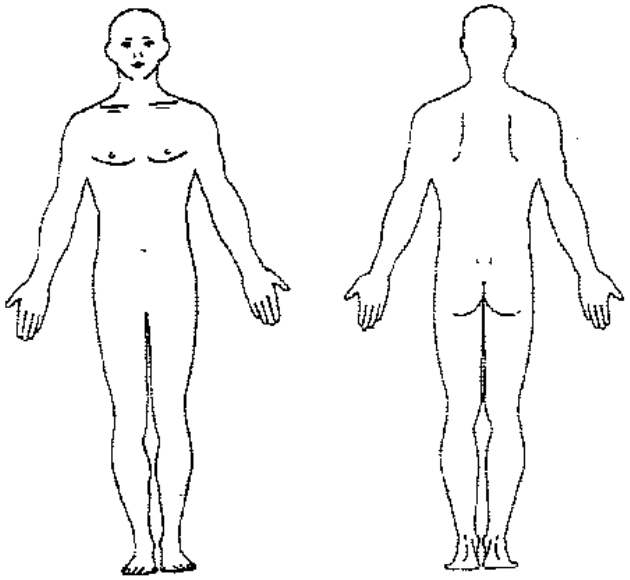
**_____**

**1 2 3 4 5 6 7 8 9 10**
**NO PAIN UNBEARABLE**

**On the diagram to the right please mark your areas of pain using the following symbols.**

**Please include all affected areas.**

**++ Numbness ## Weak**
**XX Burning ** Dull Aching**
**00 Pins & Needles == Other _____**
**// Sharp**



**Please circle all the activities that you find difficult to do NOW due to your discomfort.**

-Sleep through the night
-Crawl on all fours
-Push or pull vacuum or lawn mower
-Get out of bed
-Carry laundry basket, groceries, or child
-Turn door knob
-Make your bed
-Open a heavy door
-Wash windows or walls
-Bathe yourself
-Sit in a chair for 30 minutes
-Shovel snow or dirt
-Wash, comb or dry hair
-Sit and work at a desk for 1 hour
-Bend over to clean bathtub
-Bend over a sink for 10 min.
-Use pencil, scissors, screwdriver or pliers
-Get up from low seat
-Go to the bathroom
-Cross legs
-Lift heavy suitcase (about 40 lbs.)
-Put on socks, shoes, clothing
-Reach in front or overhead to high shelf
-Walk for one mile
-Walk up one flight of stairs
-Stand for 30 minutes
-Enjoy hobbies or social activities
-Walk down one flight of stairs
-Travel on journeys that take over 1 hour
-Enjoy sexual activities

**Are there any of the above activities that you had a difficult time doing before you had this discomfort?**
_____

**Approximate Height _____ Weight_____**

## PAST MEDICAL HISTORY

Reviewed with Patient _____

**Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)**

__Broken or fractured bones
__Osteoarthritis
__Eating Disorder
__Circulatory Problems
__Epilepsy
__Alcoholism
__Rheumatoid Arthritis
__Diabetes
__Pace Maker
__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? YES NO If YES, how long? _____**

**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_____**
_____

**WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant?**
**Yes_____ No_____ Uncertain_____ Date of last menstrual period_____**

## SOCIAL HISTORY:

Reviewed with Patient_____

**Do you drink alcoholic beverages? YES NO If so, how much per week? _____**
**Do you use any tobacco products? YES NO Do you smoke? YES NO If so, packs per day: _____**
**Do you take vitamin supplements? YES NO If so, please list: _____**
**_____**
**Do you consume caffeine? YES NO If so, how much per day? _____**
**Do you exercise? YES NO 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:

Reviewed with Patient _____

**Father: living___ deceased___ Current age if living_____ Cause of death and age if deceased:_____**
**_____**

**Mother: living___ deceased___ Current age if living___ Cause of death and age if deceased:_____**
**_____**

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

**Do you have any family members who suffer from the same condition you do? If so please list:_____**
**_____**
**_____**

### FAMILY DISEASES

**(check if applicable and indicate whether family member is Father, Mother, Sister, Brother)**

**Tuberculosis____** **Asthma____** **Kidney Disease____**
**Cancer____** **Heart Disease____** **Lung Disease____**
**Mental Illness____** **Stroke____** **Arthritis____**
**Diabetes_____** **Liver Disease____**
**Other_____**

**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 payers 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 available at the front desk. 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: _____
Doctor's Signature: _____ Date: _____

# Patient Health Information Consent Form

We want you to know 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 the 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 the 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 to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect 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 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

_____

Signature of Patient Date