

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: _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ 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? _____

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: _____

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.

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: _____

PATIENT NAME _____

DATE _____

Doctor _____

HISTORY OF PRESENT AND PAST 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: _____

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: _____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

Have you had or do you now have any of the following symptoms/conditions? 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 _____	_____	Loss of Balance _____
Neck Pain _____	_____	Fainting _____
Stiff Neck _____	_____	Loss of Smell _____
Sleeping Problems _____	_____	Loss of Taste _____
Back Pain _____	_____	Unusual Bowel Patterns _____
Nervousness _____	_____	Feet Cold _____
Tension _____	_____	Hands Cold _____
Irritability _____	_____	Arthritis _____
Chest Pains/Tightness _____	_____	Muscle Spasms _____
Dizziness _____	_____	Frequent Colds _____
Shoulder/Neck/Arm Pain _____	_____	Fever _____
Numbness in Fingers _____	_____	Sinus Problems _____
Numbness in Toes _____	_____	Diabetes _____
High Blood Pressure _____	_____	Indigestion Problems _____
Difficulty Urinating _____	_____	Joint Pain/Swelling _____
Weakness in Extremities _____	_____	Menstrual Difficulties _____

PATIENT NAME _____

DATE _____

Doctor _____

- | | | | |
|------------------------|-------|----------------------|-------|
| Breathing Problems | _____ | Weight Loss/Gain | _____ |
| Fatigue | _____ | Depression | _____ |
| Lights Bother Eyes | _____ | Loss of Memory | _____ |
| Ears Ring | _____ | Buzzing in Ears | _____ |
| Broken Bones/Fractures | _____ | Circulation Problems | _____ |
| Rheumatoid Arthritis | _____ | Seizures/Epilepsy | _____ |
| Excessive Bleeding | _____ | Low Blood Pressure | _____ |
| Osteoarthritis | _____ | Osteoporosis | _____ |
| Pacemaker | _____ | Heart Disease | _____ |
| Stroke | _____ | Cancer | _____ |
| Ruptures | _____ | Coughing Blood | _____ |
| Eating Disorder | _____ | Alcoholism | _____ |
| Drug Addiction | _____ | HIV Positive | _____ |
| Gall Bladder Problems | _____ | Depression | _____ |
| Ulcers | _____ | | |

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
 OFTEN= "O" SOMETIMES= "S" NEVER= "N"

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

PATIENT NAME _____

DATE _____

Doctor _____

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	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
HighBlood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.
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. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. 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.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. 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

For further information regarding this notice, please contact our Doctor at (606)-340-1784

INFORMED CONSENT

PATIENT NAME _____

Clinic Name _____

Doctor's Name _____

Address _____

Phone _____ Fax _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)