Chiropractic Case History/Patient Information

Date: _________________ Patient # ___________ **Doctor: Melanie Griffin Spann**

Name:___________________________ Social Security #__________________Home Phone: _______________

Address:_____________________________________City:___________________ State:______ Zip:___________

E-mail address:_____________________________Fax # __________________ Cell Phone:__________________

Preferred Phone Number for Contact:__________________________

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?___________

HISTORY OF PRESENT 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:______________________________

PAST MEDICAL HISTORY

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:____

Please list any other health problems you have, no matter how insignificant they may be:____
____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_________________________________
Do you use any tobacco products?______Do you smoke?____ If so, packs per day: _______________________
Do you take vitamin supplements?________ If so, please list:_______________________________________
Do you consume caffeine?____ If so, how much per day:____
Do you exercise?__________ 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:

Parents:

Father: living___ deceased____ Current age if still living:______ Cause of death and age at death if deceased:____________________ (check one)

Mother: living___ deceased____ Current age if still living:______ Cause of death and age at death if deceased:____________________ (check one)

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:____

Please circle any and all insurance coverage that may be applicable in this case**:**

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π 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. 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:________________

Patient Name________________________________ Date___________________________

LIFELINE CHIROPRACTIC CONFIDENTIAL
HEALTH HISTORY

The items below may relate to your current condition. In the space in front of each item, enter (Y) if you have EVER HAD the problem, enter (N) if you NEVER HAD the problem or enter (YN) if you are CURRENTLY HAVING the problem.

General

1.___ Fever
2,___ Chills
3.___ Night Sweats
4.___ Loss of Sleep
5.___ Fatigue
6.___ Nervousness
7.___ Weight Loss or Gain
8.___ Allergies
9.___ Bleeding Problems
10.___ Anemia
11.___ Diabetes
12.___ Cancer
13.___ Thyroid Disease/Goiter
14.__ _ Alcoholism
15.___ Drug Abuse

Ears, Eyes, Nose, Throat

16.___ Poor Vision
17.___ Pain in Eye(s)
18.___ Deafness/Difficulty Hearing
19.___ Nosebleeds
20.___ Nose Problems
21___Sinus Trouble
22.___ Dental Problems
23.___ Hoarseness
24.___ Tonsillectomy

Gastrointestinal

25.___ Poor Appetite
26.___ Poor Digestion
27.___ Difficulty Swallowing
28.___ Belching or Gas
29.___ Frequent Nausea
30.___ Vomiting
31.___ Vomiting Blood
32.___ Pain Over Abdomen
33.___ Ulcer
34.___ Black or Bloody Stool
35.___ Liver Problems
36.___ Gall Bladder Problems
37.___ Jaundice
38.___ Hernia
39.___ Diarrhea
40.___ Constipation
41.___ Hemorrhoids
42.___ Appendicitis

Men Only

43.___ Testicular Swelling/Pain
44.___ Prostate Problems

Respiratory

45. ___ Difficulty in Breathing
46. ___ Chronic Cough
47. ___ Spitting Phlegm
48. ___ Spitting Blood
49. ___ Wheezing/Asthma
50. ___ Pneumonia
51. ___ Tuberculosis

Cardiovascular

52. ___ Irregular Heartbeat
53. ___ High Blood Pressure
54. ___ Pain Over Heart
55. ___ Previous Heart Trouble
56. ___ Ankle Swelling
57. ___ Varicose Veins
58. ___ Rheumatic Fever
59. ___ Stroke

Genitourinary

60. ___ Frequent Urination
61. ___ Painful Urination
62. ___ Blood in Urine
63. ___ Kidney Disease
64. ___ Urinary Infection
65. ___ Inability to Control Urination
66. ___ Difficulty Starting Urine Flow
67. ___ Get Up at Night to Urinate
68. ____ Breast Lump
69. ___ Venereal Infection
70. ___ Sexual Difficulties

Skin

71. ___ Itching
72. ___ Bruising Easily
73. ___ Change in Mole(s)
74. ___ Skin Cancer
75. ___ Scars Location

Neurological

76. ___ Weakness
77. ___ Twitching
78. ___ Tremors
79. ___ Headache
80. ___ Fainting
81. ___ Dizziness
82. ___ Convulsions
83. ___ Epilepsy/Seizures
84.____ Numbness/Tingling
85. ___ Arm/Leg Pain
86.____Mental Disorder

Musculoskeletal

87.____Neck Stiffness/Pain
88. ___Pain Between Shoulders
89. ___Low Back Pain
90.____Swollen Joints
91.____Painful Joints
92. ___Muscle Aches/Soreness
94.____Arthritis

Women Only

95.____Painful Periods
96. ___Excessive Flow
97.____Irregular Cycles
98.____Vaginal Burning/Itching
99.. ___Hot Flashes
100.____ Date Last Period Began
101.____ Date of Last Pap Smear

Exercise

102. ___ None
103. ___ 1-2 Times/Week
104. ___ 3-5 Times/Week
105. ___ 6-7 Times/Week

Habits

106.____Smoking___#Packs/Day
107.___ Drinking
108.____ Recreational Drug Use
109. Caffeine

Family History

Do not include yourself!
(Include information on brothers, sisters, parents, and grandparents)

110. ___ Diabetes
111. ___ Thyroid Disease/Goiter
112. ___ Tuberculosis
113. ___ Kidney Disease
114. ___ High Blood Pressure
115. ___ Heart Disease
116. ___ Cancer
117. ___ Muscle, Bone or Nerve Disease
118. ___Lung Disease
119. ___ Ulcers
120. ___Arthritis
121. ___Seizures/Strokes

____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Lifeline Chiropractic, Inc.
Dr. Melanie Griffin
5920 Hwy. 5 North, Suite 7
Bryant, Arkansas 72022

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Lifeline Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: ___________________________________

Date: ____________________