40 Brookwood Avenue, Carlisle, PA 17015 ** (717) 609-1333

Case History/Patient Information

Date:_____ Name:_____ Nickname:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ E-mail address:_____

Would you like appointment reminders? Y N If yes, how would you like to receive them? Call Text Email

Age:_____ Birth Date:_____ Marital: M S W D Race:_____

Social Security #_____ License # : _____

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone: _____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____ Names of Children:_____

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 Insured: _____ Birth Date: _____

Name of Secondary Insurance Company (if any):_____

Name of Insured: _____ Birth Date: _____

The following person(s) have my permission to receive my personal health information:

Name:_____ Relationship:_____

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.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____DATE _____

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	_____	Rheumatoid Arthritis	_____
Neck Pain	_____	Fainting	_____	Excessive Bleeding	_____
Stiff Neck	_____	Loss of Smell	_____	Osteoarthritis	_____
Sleeping Problems	_____	Loss of Taste	_____	Pacemaker	_____
Back Pain	_____	Unusual Bowel Patterns	_____	Stroke	_____
Nervousness	_____	Feet Cold	_____	Ruptures	_____
Tension	_____	Hands Cold	_____	Eating Disorder	_____
Irritability	_____	Arthritis	_____	Drug Addiction	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____	Gall Bladder Problems	_____
Dizziness	_____	Frequent Colds	_____	Seizures/Epilepsy	_____
Shoulder/Arm Pain	_____	Fever	_____	Low Blood Pressure	_____
Numbness in Fingers	_____	Sinus Problems	_____	Osteoporosis	_____
Numbness in Toes	_____	Diabetes	_____	Heart Disease	_____
High Blood Pressure	_____	Indigestion Problems	_____	Cancer	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____	Coughing Blood	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____	Alcoholism	_____
Breathing Problems	_____	Weight Loss/Gain	_____	HIV Positive	_____
Fatigue	_____	Depression	_____	Ulcers	_____
Lights Bother Eyes	_____	Loss of Memory	_____		
Ears Ring	_____	Buzzing in Ears	_____		
Broken Bones/Fractures	_____	Circulation Problems	_____		

PATIENT NAME _____DATE _____

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 Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood 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 _____