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:_____Spouse:_____Occupation:_____

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?_____

Have you had or do you now have any of the following symptoms/conditions? **Check if Yes.**

Headaches_____ *Frequency* _____ Loss of Balance_____Neck Pain_____Cancer_____
Stiff Neck _____Sleeping Problems _____Back Pain_____Nervousness_____Stroke_____
Feet Cold_____Tension_____Hands Cold_____Arthritis_____Chest Pains/Tightness_____
Muscle Spasms_____Dizziness_____Frequent Colds_____Shoulder/Neck/Arm Pain _____
Numbness in Fingers_____Sinus Problems_____Numbness in Toes_____Diabetes_____
High Blood Pressure_____ Fatigue_____Indigestion Problems_____Joint Pain/Swelling_____
Weakness in Extremities_____Weight Loss/Gain_____Depression_____Loss of Memory_____
Ears Ring_____Broken Bones/Fractures_____Rheumatoid Arthritis_____ Seizures/Epilepsy_____
Low Blood Pressure_____Osteoarthritis_____Osteoporosis_____Pacemaker_____
Heart Disease_____

SOCIAL HISTORY:

Do you take any supplements or vitamins (please describe):_____

Do you exercise? How often? Please Describe:_____
How much of the day are you: bending _____lifting_____sitting_____computer work_____
Tobacco Use? _____ Drug Use_____

HISTORY OF PRESENT AND PAST ILLNESS:

Is this due to: Auto___ Work____ Other_____

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 of any kind? Yes No

If yes, describe:_____

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

Please check 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:_____

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.

*Our office may contact you periodically regarding appointments, treatment, products, services, or charitable work performed by our office. You may choose to opt out of any marketing or fundraising communications at any time.

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:

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

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Summary

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. 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? _____
4. How frequent is the condition? Constant_____Daily_____Intermittent_____Night Only_____
   How long does it last? All Day_____Few Hours_____Minutes_____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes_____No_____. If yes, describe:_____
6. Describe the pain: Sharp_____Dull_____Numbness_____Tingling_____Aching_____
   Burning_____Stabbing_____Other_____
7. 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? _____
   _____
8. What makes the problem worse? Standing_____Sitting_____Lying_____Bending_____
   Lifting_____ Twisting_____ Other_____
9. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
   Yes_____No_____Uncertain_____
10. Remarks: _____
    _____