

# Whole Life 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:](#)**

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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? \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

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 _____
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 Acknowledgement and Receipt of  
Notice of Privacy Practices Pursuant to HIPAA and Consent  
for Use of Health Information**

Name \_\_\_\_\_

Date \_\_\_\_\_

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By \_\_\_\_\_

Signature of Parent/Guardian (circle one)

**Whole Life Chiropractic**  
107 South Main Street  
Necedah, WI 54646  
**608-565-7600**

**INFORMED CONSENT**

**PATIENT NAME** \_\_\_\_\_

The primary treatment used by doctors of chiropractic is the spinal manipulation or adjustment.

- **The nature of the chiropractic adjustment:**
  - I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. This procedure is referred to as a “Spinal Manipulation” or Spinal Adjustment”.
  
- **The material risks inherent in chiropractic adjustment:**
  - As with any health care procedure, there are certain complications that can occur as a result of a chiropractic 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.
  
- **The probability of those risks occurring:**
  - Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination. Stroke has at most a one-in-a-million outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare”.

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)