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? ☐ yes ☐ no

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:_____

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	_____
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
_____ Moderate Exercise
_____ Alcohol Use
_____ Drug Use
_____ Tobacco Use
_____ Caffeine
_____ High Stress Activity

_____ Family Pressures
_____ Financial Pressures
_____ Other Mental Stresses
_____ Other (specify)_____
_____
_____

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	Sister	Children
Arthritis						
Asthma-Hay Fever						
Back/Dics Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Emphysema						
Epilepsy						
Headaches/Migraines						
High Blood Pressure						
Insomnia						
Kidney/liver Trouble						
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 _____

Consent to Treatment

I hereby authorize Dr. Annie Wood and whomever he/she may designate as his/her assistants to administer treatment as he/she so deems necessary

Signature_____

IF YOU ARE CONSENTING ON BEHALF OF AN ADULT, DO YOU HAVE MEDICAL POWER OF ATTORNEY? _____

(Please provide our office with a copy of the medical Power of Attorney).

Witnessed: _____

PRENATAL CHIROPRACTIC INTAKE FORM

Thank you for allowing us the opportunity to be a part of your pregnancy health care. This form is to be completed in addition to our regular patient history so we can better serve you throughout your pregnancy.

Name: _____ Date: _____

CURRENT PREGNANCY

Due Date/Week: _____ I am in my: _____ week of pregnancy.
Pre-pregnancy weight: _____ Current weight: _____ Height: _____
Childbirth preparation: Bradley_____ LaMaze_____ Other_____
Childbirth caregiver(s): OB/GYN _____ Doula _____ Midwife _____
Last visit to Caregiver: ____/____/____
Caregiver's name and phone # _____
I plan on giving birth at: Hospital _____ Home _____ Birth Center _____
Name of Hospital or Birth Center _____
What position do you sleep in? Side _____ Back _____ Stomach _____
Any traumas during this pregnancy? If yes, Please describe : _____
_____
Any hospitalizations during this pregnancy? If yes, Please describe: _____
_____
Any medications during this pregnancy, including over the counter medication? Please Describe: _____
Any fertility treatment? If yes, Please describe: _____
_____
Any other information you would like us to know about you and your pregnancy?
_____
_____

PREVIOUS PREGNANCIES/BIRTHS

of previous pregnancies: _____ # of previous births ____ Please explain any difference in numbers: _____
Names & ages of children: _____

Your previous births were at: Hospital _____ Home _____ Birth Center _____
Medications used in prior births: None _____ Ptocin _____ Epidural _____
Interventions used in prior births: Breaking of water _____ Vacuum _____ Forceps _____
Episiotomy _____
How long was your previous labor? Total: _____ Time before you pushed: _____
Time you spent pushing: _____
Did you have chiropractic care during your previous pregnancies? Y_____ N_____

AFTER 32ND WEEK OF PREGNANCY

Position of baby: Head down _____ Posterior _____ Breech or malposistioned _____
Confirmed by: Palpation by_____ on _____/_____/_____
Ultrasound by _____ on _____/_____/_____
How long do you believe baby has been in this position? _____

THE WEBSTER TECHNIQUE DEFINED

International Chiropractic Pediatric Association definition of Webster Technique:

The Webster technique is a specific chiropractic analysis and adjustment that reduces Interference to the nervous system, balances out pelvic muscles and ligaments which in turn removes torsion to the uterus, reducing the potential for intra-uterine constraint and allows the baby to get into the best possible position for birth.

Statement to pregnant patients of Annie Wood, DC

I understand that Annie Wood, DC provides chiropractic adjustments to treat Musculoskeletal complaints in patients, including pregnant women.

_____

Print Name Sign Name Date

PEDIATRIC CHIROPRACTIC INTAKE FORM

Thank you for allowing us the opportunity to take care of you and your family. Please complete the following information so we can better serve your child. It is a pleasure to welcome you to our chiropractic family.

Child's Name _____ DOB: ____/____/____ SS# _____ Age _____
Sex M / F Height _____ Weight _____ # of Siblings _____
Name of Parents/ Guardians _____
Address_____ City _____ State_____ Zip _____
Home Phone # _____ Mother's Cell #_____ _____
Father's Cell # _____ Parent Email _____
How did you hear about our office? _____
Reason(s) for seeking care _____
Other doctors seen for this condition (circle) Yes / No
If yes, doctor name(s) and prior treatment: _____

OTHER HEALTH PROBLEMS

Please check any current or past problems your child has had on the list below:

__Dizziness	__Diabetes	__Anemia	__Broken Bones
__ADHD	__Tuberculosis	__Rheumatic Fever	__Sprains/Strains
__Autism	__Hypertension	__Poor Appetite	__Fainting
__Backaches	__Arthritis	__Hyperactivity	__Hernias
__Neck pain	__Heart Condition	__Behavioral	__Arm/Elbow Pain
__Headaches	__Rashes/Hives	__Poor Memory	__Leg/Hip Pain
__Allergies	__Digestive	__Insomnia	__Knee/Foot Pain
__Asthma	__Sinus Trouble	__Nightmares	__Growing Pains
__Runny Nose	__Neuritis	__Bed Wetting	__Joint Pain
__Itchy Eyes	__Cough/Wheeze	__Pain Urinating	__Scoliosis
__Chronic Ear Infections	__Chest Pain	__Convulsions	__Blood Disorders
__Frequent Colds	__Constipation	__Paralysis	__Stomach Aches
__Fever/Chills	__Diarrhea	__Muscle Pain	__Other

HEALTH HISTORY

Previous Chiropractor(s): _____ Reason for Care:_____
Name of Pediatrician: _____ Date of last visit: _____
Reason for visit: _____
Number of antibiotics taken in lifetime:_____ Condition(s) treated: _____
Medications and conditions being treated: _____
Has your child been injured in any type of accident (ie. Sports, car accident, major fall, etc.)? Y/N
If yes, please describe with dates:_____
Prior surgeries? Y/N Type and Date: _____
Vaccination History: _____

PRENATAL HISTORY

Childbirth caregiver(s): OB/GYN _____ Doula _____ Midwife _____
Location of birth: Hospital _____ Home _____ Birth Center _____
Medications used during birth: None _____ Ptocin _____ Epidural _____

Interventions used during birth: Breaking of water ____ Vacuum _____ Forceps ____ Episiotomy _____
Position of baby at birth: Head down _____ Posterior _____ Breech or malposistioned _____
How long was your labor? _____
Complications during pregnancy: Y/N If yes, Please describe_____
Complications during delivery: Y/N If yes, Please describe: _____
Did you have chiropractic care during your pregnancy? Y/N
Cigarette/Alcohol use during pregnancy: Y/N
Ultrasound during pregnancy: Y/N
Cesarean: Y/N Planned _____ Emergency _____
Genetic Disorder/Disability? Y/N If yes, Please describe: _____
Birth weight _____ Birth length _____
APGAR scores _____

FEEDING HISTORY

Breast Fed: Y/N How long? _____
Formula Fed: Y/N How long? _____
Type of formula:_____
Introduced to solids at _____ months, Cow's milk at _____ months
Food/ juice allergies or intolerances: Y/N Please List: _____

DEVELOPMENTAL HISTORY

Number of hours sleeping per night _____ Quality of sleep: Good / Fair / Poor
At what age was your child able to:

Respond to sound _____	Follow object with eyes _____	Hold head up _____
Crawl _____	Sit alone _____	Stand alone _____
Walk alone _____	Say words _____	

CHILDHOOD DISEASES

At what age (if ever) did your child suffer from the following:
Chicken Pox _____ Rubella _____ Measles _____
Mumps _____ Whooping Cough _____ Other_____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

_____

Parent or Guardian-Print Signature Date