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 payers 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:________________

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?____

Please list any of the following, (Include dates):

Serious Illnesses: ____

Major Surgeries: ____

Serious Injuries: ____

Broken Bones: ____

Child Birth: ____

____

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 or could you possibly be pregnant? ( ) Yes ( ) No

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

Symptom/Condition		Symptom/Condition	
Headaches	________	Loss of Balance	__________
Neck Pain	________	Fainting	__________
Stiff Neck	________	Loss of Smell	__________
Sleeping Problems	________	Loss of Taste	__________
Back Pain	________	Bowel Problems	__________
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	__________

PATIENT NAME ____

DATE ____________________

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	________	Venereal Disease	__________
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

Rate your level of Stress: ( ) High ( ) Moderate ( ) Low

Appetite: ( ) Excessive ( ) Normal ( ) Suppressed

Family History: ( ) Cancer ( ) Diabetes ( ) High Blood Pressure
( ) Heart Problems/Stroke ( ) Rheumatoid Arthritis ( ) Lung Problems

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ______________________________________ Date: _________________________