

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: _____

Emergency Contact: _____ Relationship _____

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): _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Address: _____

Policy Holder's Employer's Name and Address: _____

Relationship to Policy Holder: _____

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? _____

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 _____

PATIENT NAME _____

DATE _____

Breathing Problems _____
Fatigue _____
Lights Bother Eyes _____
Ears Ring _____
Broken Bones/Fractures _____
Rheumatoid Arthritis _____
Excessive Bleeding _____
Osteoarthritis _____
Pacemaker _____
Stroke _____
Ruptures _____
Eating Disorder _____
Drug Addiction _____
Gall Bladder Problems _____
Ulcers _____

Weight Loss/Gain _____
Depression _____
Loss of Memory _____
Buzzing in Ears _____
Circulation Problems _____
Seizures/Epilepsy _____
Low Blood Pressure _____
Osteoporosis _____
Heart Disease _____
Cancer _____
Coughing Blood _____
Alcoholism _____
HIV Positive _____

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) _____

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									
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 _____