Chiropractic Case History/Patient Information

Date:_____ Dr. Taylor Wilbeck D.C.

Name:_____ Social Security #_____ Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax # _____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D Spouse:_____

Occupation:_____ Employer:_____ Work Phone: _____

Emergency Contact: _____ Relationship: _____Phone: _____

How were you referred to our office?_____ Family Physician: _____

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 circle any and all insurance coverage that may be applicable in this case**:**

Major Medical, Worker's Compensation, 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 rendered 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:

Name(s):_____**Relationship:** _____

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 or No If yes, 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? _____

_____

What medications or drugs are you taking?_____

Do you have any allergies to any medications? π Yes π No

If yes, describe:_____

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

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

Women: Are you pregnant?_____

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)_____

_____

_____

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	
Back Pain	_____	Unusual Bowel Patterns	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Dizziness	_____	Frequent Colds	_____

N = Now P = Previously

Drug Addiction	_____	HIV Positive	_____
Ears Ring	_____	Buzzing in Ears	_____
Eating Disorder	_____	Alchoholism	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Fatigue	_____	Depression	_____
Gall Bladder Problems	_____	Depression	_____
Headaches_____ Frequency	_____	Loss of Balance	_____
High Blood Pressure	_____	Indigestion Problems	_____
Irritability	_____	Arthritis	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Neck Pain	_____	Fainting	_____
Nervousness	_____	Feet Cold	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Ruptures	_____	Coughing Blood	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Sleeping Problems	_____	Loss of Taste	_____
Stiff Neck	_____	Loss of Smell	_____
Stroke	_____	Cancer	_____
Tension	_____	Hands Cold	_____
Ulcers	_____	Migraines	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as" Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These compilations 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 oculosympathethetic 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.

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 you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____