Chiropractic Case History/Patient Information

Date:__________________ Patient #___________ **Doctor:**___________________
(Office use only) CHIRO EXP YES_____NO______

Name:___________________________ Social Security #__________________Cell Phone: _______________

Address:_____________________________________City:___________________ State:______ Zip:___________

E-mail address:_____________________________Fax # __________________ Cell Carrier:__________________

Age:_______ Birth Date:___________ Race:______ Marital: M S W D Occupation:______________________

Employer:_____________________________________Spouse:____________________Occupation:____________

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?___________ ***OFFICE USE ONLY*** **Ht_________Wt________B/P___________Pul_________**

Have you had or do you now have any of the following symptoms/conditions? **Check if Yes.**

Headaches______ *Frequency* ________ Loss of Balance__________Neck Pain________Cancer_______
Stiff Neck ________Sleeping Problems ________Back Pain________Nervousness________Stroke___________
Feet Cold__________Tension________Hands Cold__________Arthritis_________Chest Pains/Tightness________
Muscle Spasms________Dizziness________Frequent Colds________Shoulder/Neck/Arm Pain ________
Numbness in Fingers________Sinus Problems__________Numbness in Toes________Diabetes__________
High Blood Pressure________ Fatigue________Indigestion Problems_________Joint Pain/Swelling_________
Weakness in Extremities________Weight Loss/Gain__________Depression__________Loss of Memory__________
Ears Ring________Broken Bones/Fractures________Rheumatoid Arthritis________ Seizures/Epilepsy__________
Low Blood Pressure__________Osteoarthritis________Osteoporosis__________Pacemaker_______
Heart Disease__________

SOCIAL HISTORY:

Do you take any supplements or vitamins (please describe):____

Do you exercise? How often? Please Describe:____
How much of the day are you: bending ___________lifting___________sitting_________computer work________
Tobacco Use? _____________ Drug Use_______________

HISTORY OF PRESENT AND PAST ILLNESS:

Is this due to: Auto___ Work____ Other____

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 of any kind? Yes No

If yes, describe:____

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

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

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other
Name of Primary Insurance Company:____

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.

*Our office may contact you periodically regarding appointments, treatment, products, services, or charitable work performed by our office. You may choose to opt out of any marketing or fundraising communications at any time.

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:

____

____

I certify the information provided is accurate to the best of my knowledge:

Patient's Signature:____ Date:________________

Guardian's Signature Authorizing Care:_____________________________________ Date:________________

Summary

1. What is your major symptom? ____
2. What does this prevent you from doing or enjoying? ____
3. If this is a recurrence, when was the first time you noticed this problem? ___________________________

   How did it originally occur? ____

   Has it become worse recently? Yes____No______Same_____ Better______Gradually Worse__________

   If yes, when and how? ____
4. How frequent is the condition? Constant_______Daily______Intermittent________Night Only_________

   How long does it last? All Day________Few Hours____________Minutes___________________
5. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes_________No________. If yes, describe:____
6. Describe the pain: Sharp_______Dull_________Numbness_______Tingling_________Aching_________

   Burning_______Stabbing_________**Pain level 1 to 10, 10 worst**___________________________________
7. Is there anything you can do to relieve the problem? Yes______No________. If yes, describe__________

   ___________________. If no, what have you tried to do that has not helped? _______________________

   ____
8. What makes the problem worse? Standing_______Sitting______Lying_______Bending_______

   Lifting______ Twisting________ Other____
9. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

   Yes_______No_________Uncertain_________
10. Remarks: ____

    ____