

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 (first and last name): _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT 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: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Ulcers

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents, hospitalizations 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: _____

Please list any other health problems you have, no matter how insignificant they may be:

SOCIAL HISTORY:

Do you drink alcoholic beverages? If so, how much per week? _____

Do you use any tobacco products? Do you smoke? If so, packs per day: _____

Do you take vitamin supplements? If so, please list: _____

Do you consume caffeine? If so, how much per day: _____

Do you exercise? If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting sitting bending working at a computer

FAMILY HISTORY:

Parents:

Father: living deceased (check one) Current age if still living: _____ Cause of death and age at death if deceased: _____

Mother: living deceased (check one) Current age if still living: _____ Cause of death and age at death if deceased: _____

Check if applicable to you: As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis

Cancer

Mental Illness

Diabetes

Asthma

Heart Disease

Stroke

Kidney Disease

Lung Disease

Arthritis

Liver Disease

High Blood Pressure

Other _____

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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Case History

Name _____ **Date** _____

1. What is your major symptom? _____

Other symptoms _____

Other symptoms _____

Other symptoms _____

Other symptoms _____

2. 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? _____

3. Is there any radiating pain? If so, where? _____

4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___

How long does it last? All Day ___ Few Hours ___ Other _____

5. Are there any other conditions or symptoms that may be related to your major symptom?

Yes ___ No _____. If yes, describe: _____

Are there other unrelated health problems? Yes ___ No _____. If yes, describe _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___

Burning ___ Stabbing ___ Other _____

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. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes ___ No ___ Uncertain _____

11. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____