

Chiropractic Case History and Patient Information

Name		Today's Date:	
Street Address			
City/State/Zip			
Birth Date		Social Security #	
Age		Home Phone	
Race		Cell Phone	
Marital Status M – S- W- D		Email Address:	
How many Children?			
Name & Ages of Children			
Emergency Contact Name & Phone			
Family Medical Doctor Name & Phone			
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?			
How were you referred to our office			

EMPLOYMENT INFORMATION

Occupation			
Employer		Employer's Phone	
Employer's Address			
Spouse's Occupation			
Spouse's Employer			

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)					
Broken or Fractured Bones		Cancer		Excessive Bleeding	
Circulatory Problems		Ruptures		High/Low Blood Pressure	
Rheumatoid Arthritis		Coughing Blood		Osteoarthritis	
Seizures/Convulsions		Eating Disorder		Epilepsy	
A Congenital Disease		Alcoholism		Pace Maker	
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? If yes, describe					
What medications or drugs are you taking?					
Do you have any allergies to any medications? If yes, describe					
Do you have any allergies of any kind? If yes, describe					
Please list any other health problems you have, no matter how insignificant they may be:					

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SOCIAL HISTORY				
Do you drink alcoholic beverages?		If so, how much per week?		
Do you use any tobacco products?		If so, how 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) do you spend	Working at a computer	Sitting	Bending	Lifting

FAMILY HISTORY			
Parents	Living or Deceased	Age	Cause of death and age at death if deceased
Father			
Mother			
FAMILY DISEASES (check if applicable and indicate whether family member is <u>F</u> ather, <u>M</u> other, <u>S</u> ister, <u>B</u> rother):			
Check if applicable to you. As an adopted child, little is known of birth parents or family.			
Tuberculosis		Cancer	Mental Illness
Diabetes		Asthma	Heart Disease
Stroke		Kidney Disease	Lung Disease
Arthritis		Liver Disease	
Other			

INSURANCE INFORMATION			
Please check any and all insurance coverage that may be applicable in this case:			
Major Medical		Worker's Compensation	
Medicaid		Auto Accident	
Medicare		Medical Savings Account & Flex Plans	
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:

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HISTORY OF PRESENT ILLNESS	
1.	Chief Complaint: Purpose of this appointment
2.	Date symptoms appeared or accident happened. Is this due to: Auto ____ Work____ Other
3.	Have you ever had the same or a similar condition? If yes, when and describe
4.	Days lost from work?
5.	Date of last physical examination?
6.	What is your major symptom?
7.	What does this prevent you from doing or enjoying?
8.	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?
9.	How frequent is the condition? Constant ____ Daily ____ Intermittent ____ Night Only ____
10.	Are there any other conditions or symptoms that may be related to your major symptom If yes, describe
11.	Are there other unrelated health problems? If yes, describe
12.	Describe the pain: Sharp ____ Dull____ Numbness ____ Tingling ____ Aching ____ Burning ____ Stabbing____ Other
13.	Is there anything you can do to relieve the problem? If yes, describe If no, what have you tried to do that has not helped?
14.	What makes the problem worse? Standing ____ Sitting ____ Lying ____ Bending ____ Lifting ____ Twisting ____ Other
15.	List any major accidents you have had other than those that might be mentioned above.
16.	WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes ____ No ____ Uncertain ____
17.	Please place an "X" on the line below to indicate level of problem. _____ _____ No Symptoms Extreme Symptoms