Chiropractic Case History/Patient Information

Date:_____ Patient #:_____ Chiropractor: _____

Name:_____ SSN: _____

Address:_____ City:_____ State:_____ Zip: _____

Email Address:_____ Phone: □ Home □ Cell #:_____

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

Occupation:_____ Employer: _____

Employer's Address:_____ Office Phone: _____

Spouse:_____ Occupation:_____ Employer: _____

How many children?_____ Names & 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? ☐ Yes ☐ No

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 applicable): _____

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 to know how your Patient Health Information is going to be used in this office and your rights concerning these 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: _____

Patients Signature:_____ Date:_____

Guardians Signature Authorizing Care:_____ Date: _____

PATIENT NAME:_____ **Date:** _____ **Doctor:**_____

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:_____Women: are you pregnant? ☐ Yes ☐ No

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates). **PLEASE LIST ALL:** _____

_____

_____

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: _____

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	Loss of Balance
Severe Headaches or Migraines	Fainting
Neck Pain	Loss of Smell
Stiff Neck	Loss of Taste
Sleeping Problems	Unusual Bowl Patterns
Back Pain	Feet Cold
Nervousness	Hands Cold
Tension	Arthritis
Irritability	Muscle Spasms
Chest Pains/Tightness	Fever
Heart Attack	Sinus Problems
Dizziness	Diabetes
Shoulder/Neck/Arm Pain	Indigestion Problems
Numbness in Fingers	Joint Pain/Swelling
Numbness in Toes	Deep Vein Thrombosis
High Blood Pressure	Blood Clotting Disorders
Difficulty Urinating	Menstrual Difficulties
Weakness in Extremities _____	Aneurysm _____

PATIENT NAME:_____ **Date:**_____ **Doctor:**_____

HISTORY OF PRESENT AND PAST ILLNESS (CONT):

N = Now P = Previously

Breathing Problems
Fatigue
Ringing in Ears
Broken Bones/Fractures
Rheumatoid Arthritis
Excessive Bleeding
Osteoarthritis
Pacemaker
Stroke
Heart Bypass Surgery
Eating Disorder
Drug Addiction
Gall Bladder Problems
Alcoholism
Aortic Stents
Hardening of Arteries

Weight Loss
Weight Gain
Loss of Memory
Buzzing in Ears
Circulation Problems
Seizures/Epilepsy
Low Blood Pressure
Osteoporosis
Heart Disease
Cancer
Metastatic Cancer
Coughing Blood
Auto Immune Disorders
HIV Positive
High Cholesterol

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 _____
Eat a Balanced Diet _____
Other Mental Stresses _____
Other (Specify) _____

PATIENT NAME: _____

DATE: _____ CHIROPRACTOR: _____

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 client.

CONDITION	**FATHER** Age ( )	**MOTHER** Age ( )	**SPOUSE** Age ( )	**BROTHER(S)** Age ( )	**SISTER(S)** Age ( )	**CHILD(REN)** Age ( ) Age ( )
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
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 & cause: _____

_____

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

Name of Patient: _____

Signature of Patient/Legal Guardian: _____ Date: _____