Chiropractic Case History / Patient Information

Date: _____ Patient # _____ Doctor _____

Name:_____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Age: _____ Birth Date: _____ Marital: M S W D Sep.

Occupation: _____

Employer: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

_____

Name of Nearest Relative: _____ Relation: _____ Phone: _____

How were you referred to our office? Friend/Family Sign Internet Other_____

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: _____

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 the consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient Name _____ Patient # _____ Date: _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint (purpose of 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: _____

List any surgeries with dates. _____

Have you ever had any major illnesses, injuries, falls, or auto accidents? 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: _____

Do you have any Congenital Conditions? Yes _____ No _____

If yes, when and describe: _____

Women: Are you pregnant? Yes _____ No _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if these conditions you have **Now** or **P** if you have had these conditions **Previously**.

N = Now **P = Previously**

Headaches	_____	Loss of Balance	_____
Frequency _____		Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Disorders	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pain/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain / Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

Patient Name _____ Patient # _____ Date: _____

Breathing Problems/Asthma	_____	Ulcers	_____
Fatigue	_____	Weight Loss / Gain	_____
Lights Bother Eyes	_____	Depression	_____
Ears Ring / Buzz	_____	Loss of Memory	_____
Broken Bones / Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures / Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____		

Are you taking any supplements? Yes _____ No _____
Please list:

_____

_____

_____

_____

_____

Doctor's Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name _____ Patient # _____ Date: _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN = O **SOMETIMES = S** **NEVER = N**

Vigorous Exercise	_____	High Stress Activity	_____
Moderate Exercise	_____	Family Pressures	_____
Alcohol Use	_____	Financial Pressures	_____
Drug Use	_____	Other Mental Stresses	_____
Tobacco Use	_____	Other (specify)	_____
If so, how much?	_____		
Caffeine	_____		

What form of communication do you prefer? (check one)

Text _____ Email _____ Mail/Letter _____ Phone _____

	Smoking	Smokeless Tobacco
Smoking status:	_____ Current Daily Smoker	_____ Current Daily Smokeless Tobacco
	_____ Some Day Smoker	_____ Some Day Tobacco User
	_____ Former Smoker	_____ Former Tobacco User
	_____ Never Smoker	_____ Never Tobacco User

Race:

_____ Asian

_____ American Indian

_____ Black or African American

_____ White

_____ Other _____

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino

Preferred language: _____ English _____ Spanish _____ Other _____

Height _____ Weight: _____

Eye Color: _____ Hair Color: _____ Glasses: Yes _____ No _____

Education Level Completed:

Some High School _____ High School Diploma _____ Some College _____ Associate Degree _____

Bachelor Degree _____ Some Graduate School _____ Graduate School _____