

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: _____

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

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. [The following person\(s\) have my permission to receive my personal health information:](#)

 Patient's Signature: _____ Date: _____

 Guardian's 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? π Yes π No If yes, when and describe: _____

Days lost from work: _____ Date of last physical examination: _____

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? π Yes π No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? π Yes π No

If yes, describe: _____

Do you have any allergies of any kind? π Yes π No

If yes, describe: _____

Do you have any Congenital Condition? ___ Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

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_____ Frequency _____
- Neck Pain _____
- Stiff Neck _____
- Sleeping Problems _____
- Back Pain _____
- Nervousness _____
- Tension _____
- Irritability _____
- Chest Pains/Tightness _____
- Dizziness _____
- Shoulder/Neck/Arm Pain _____
- Numbness in Fingers _____
- Numbness in Toes _____
- High Blood Pressure _____
- Difficulty Urinating _____
- Weakness in Extremities _____

- Loss of Balance _____
- Fainting _____
- Loss of Smell _____
- Loss of Taste _____
- Unusual Bowel Patterns _____
- Feet Cold _____
- Hands Cold _____
- Arthritis _____
- Muscle Spasms _____
- Frequent Colds _____
- Fever _____
- Sinus Problems _____
- Diabetes _____
- Indigestion Problems _____
- Joint Pain/Swelling _____
- Menstrual Difficulties _____

PATIENT NAME _____

DATE _____

Doctor _____

Breathing Problems _____
 Fatigue _____
 Lights Bother Eyes _____
 Ears Ring _____
 Broken Bones/Fractures _____
 Rheumatoid Arthritis _____
 Excessive Bleeding _____
 Osteoarthritis _____
 Pacemaker _____
 Stroke _____
 Ruptures _____
 Eating Disorder _____
 Drug Addiction _____
 Gall Bladder Problems _____
 Ulcers _____

Weight Loss/Gain _____
 Depression _____
 Loss of Memory _____
 Buzzing in Ears _____
 Circulation Problems _____
 Seizures/Epilepsy _____
 Low Blood Pressure _____
 Osteoporosis _____
 Heart Disease _____
 Cancer _____
 Coughing Blood _____
 Alcoholism _____
 HIV Positive _____
 Depression _____

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
 _____ Financial Pressures
 _____ Other Mental Stresses
 _____ Other (specify) _____

PATIENT NAME _____

DATE _____

Doctor _____

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 climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
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 and cause:

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

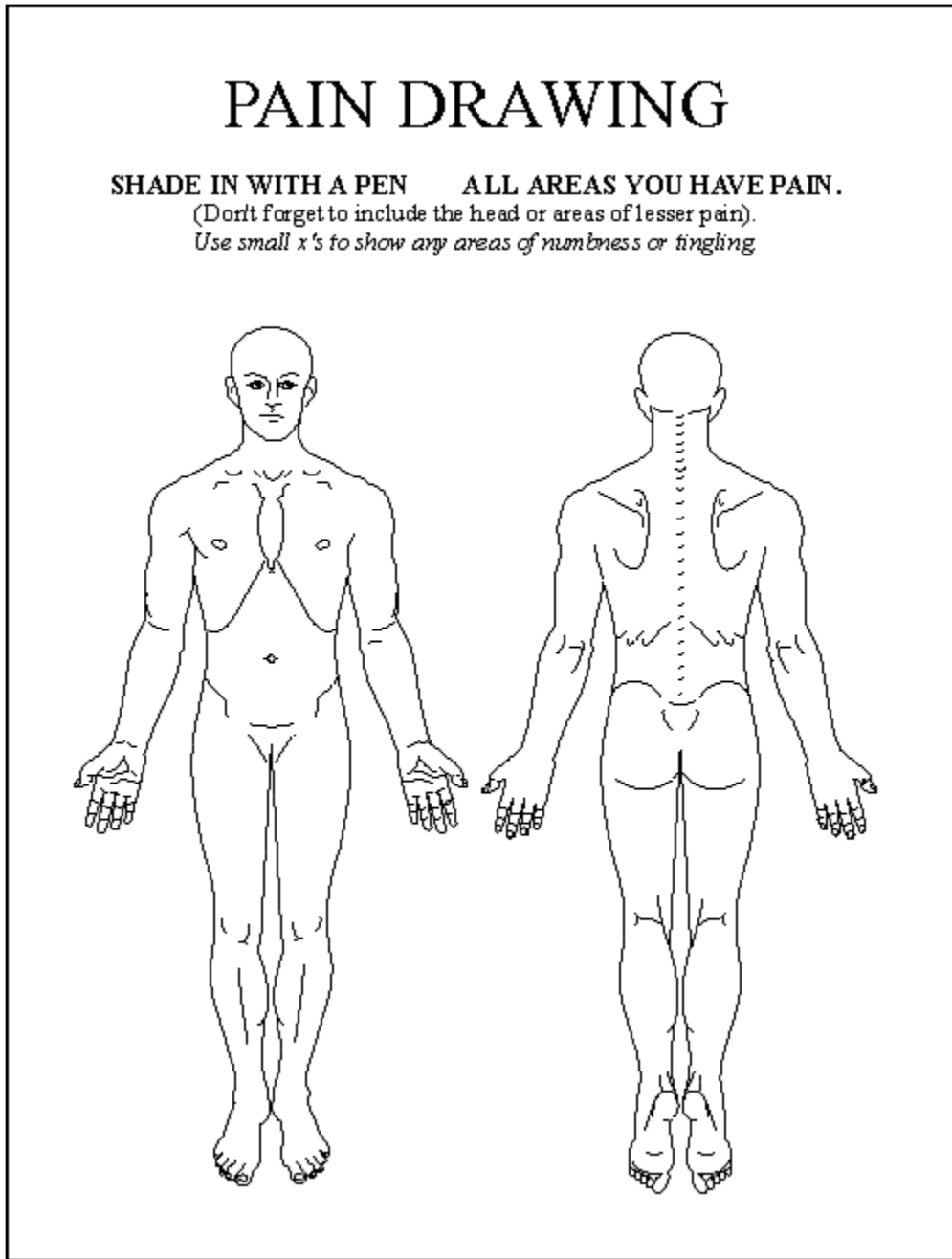
Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Name: _____

Date: _____



Please mark on the line, the pain level that most accurately represents your pain for **each** body area:

	0	1	2	3	4	5	6	7	8	9	10	
Right now:	No pain											Unbearable
Average pain:	No pain											Unbearable
At best & worst:	No pain											Unbearable

What makes it better? _____ What makes it worse? _____
What percentage of each day does it currently bother you? (Circle one) 0% 25% 50% 75% 100%

INFORMED CONSENT

PATIENT NAME _____

Clinic Name _____

Doctor's Name _____

Address _____

Phone _____ Fax _____

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)