

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

_____ Family Pressures

_____ Moderate Exercise

_____ Financial Pressures

_____ Alcohol Use

_____ Other Mental Stresses

_____ Drug Use

_____ Other (specify) _____

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

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 Age []	MOTHER Age []	SPOUSE Age []	BROTHER(S) Age [] Age []	SISTERS Age [] Age []	CHILDREN Age [] Age []
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood 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 _____