

## Chiropractic Case History/Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Home Phone \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer and address: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse Birth Date: \_\_\_\_\_

Spouse employer and address: \_\_\_\_\_

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 and subscriber number: \_\_\_\_\_

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.

**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: \_\_\_\_\_

Please understand that this chiropractic office does not participate with any insurance companies other than Medicare. We will bill your insurance company for you, however you must agree to either sign over any insurance check to us for services rendered in our office, or to bring a payment to us for the amount sent to you by your insurance company for services received in our office. If you have any questions regarding your insurances charges please bring in your EMB for an explanation of charges and payments.

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**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? \_\_\_\_\_

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? \_\_\_\_\_

 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 \_\_\_\_\_

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 _____	_____	Loss of Balance _____
Neck Pain _____	_____	Fainting _____
Stiff Neck _____	_____	Loss of Smell _____
Sleeping Problems _____	_____	Loss of Taste _____
Back Pain _____	_____	Unusual Bowel Patterns _____
Nervousness _____	_____	Feet Cold _____
Tension _____	_____	Hands Cold _____
Irritability _____	_____	Arthritis _____
Chest Pains/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 \_\_\_\_\_

DATE \_\_\_\_\_

**CONTINUED**

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
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	_____	Depression	_____
Ulcers	_____		

**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	

**ADDITIONAL PERSONAL HEALTH GOALS**

Check all that apply

_____ Weight Loss	_____ Enhanced Mental Clarity
_____ More Energy	_____ Decrease Stress
_____ Increased Performance	_____ Eliminate Bad Habits
_____ Healthy Aging	_____ Improve Lifestyle

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

### 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									
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:
 

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

Name of Patient \_\_\_\_\_

Signature of Patient/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_