Fitchett Chiropractic

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name_____ Date of birth: _____Age:_____

Address_____City_____ State _____ Zip_____

Cell:_____ Other:_____ Email:_____

Marital Status: ☐ M ☐ S ☐ W ☐ D Spouse's name:_____ # children_____

Occupation_____ Employer_____ SS #_____

Who may we thank for referring you to our office? _____

Primary Care Physician_____ May we send Report? Yes ☐ No ☐

Address/Phone Number _____

_____

HEALTH INFORMATION: Have you had previous chiropractic care? Yes ☐ No ☐

What is your major complaint & do you have any idea what caused it? _____

_____

Other complaints: _____

How long have you had this condition? _____Have you had this or similar conditions in the past? _____

What is your condition interfering with? _____

Is this condition getting progressively worse? Yes ☐ No ☐

Pain timing: Constant ☐ Comes and goes ☐

What do you do that helps to relieve the issue? _____

What treatments have you tried that did not work?_____

Other doctors who treated this condition: _____

Do you wear: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Describe_____

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe_____

REVIEW OF SYSTEMS

Below is a review of the various systems operation in your body. While these may not seem related to your spinal health care, it is important to remember that the spine houses our nervous system and can therefore affect your entire body.
Many systems work together. We ask that you select any of the following that pertains to you.

GENERAL
- ☐ Headache
- ☐ Migraines
- ☐ Fever
- ☐ Chill
- ☐ Sweats
- ☐ Night Sweats
- ☐ Fainting
- ☐ Convulsions
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Any Numbness
- ☐ Allergies
- ☐ Wheezing
- ☐ Pressure in Head
- ☐ Loss of Movement
- ☐ Confusion
- ☐ Bedwetting
- ☐ Nervousness
- ☐ Difficulty Sleeping
- ☐ Depression
- ☐ Any Tingling
- ☐ Memory Loss

MISCELLANEOUS
- ☐ Vertigo/dizziness
- ☐ Thyroid issues
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Paralysis

SKIN
- ☐ Rash
- ☐ Bruise Easily
- ☐ Slow-healing Wounds
- ☐ Hives/Allergy Itching

E/E/N/T
- ☐ Failing Vision
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Earache
- ☐ Ear Ringing
- ☐ Hay Fever
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Asthma
- ☐ Enlarged Thyroid

CARDIOVASCULAR
- ☐ Rapid Heart Rate
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Ankle Swelling
- ☐ Cold Hands/Feet
- ☐ Leg Cramps
- ☐ Chest Pain

RESPIRATORY
- ☐ Difficulty Breathing
- ☐ Chronic Cough
- ☐ Spitting up Phlegm
- ☐ Spitting up Blood
- ☐ Out of Breath Easily
- ☐ Lung Problems
- ☐ Sinus Issues

URINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Kidney Infection
- ☐ Kidney Stone
- ☐ Prostate Trouble
- ☐ Involuntary Urination

JOINT/MUSCLE
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Painful Tailbone
- ☐ Hernia
- ☐ Weakness
- ☐ Knee Pain
- ☐ Shoulder Pain
- ☐ Tremors
- ☐ Swollen Joints
- ☐ Jaw Pain
- ☐ Arm/Leg pain

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Indigestion/Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Liver Trouble
- ☐ Gallbladder Trouble
- ☐ Ulcers
- ☐ Hemorrhoids
- ☐ Bloody Stool
- ☐ Very Thirsty
- ☐ Irritable Bowel
- ☐ Other GI issues

REPRODUCTIVE (Female)
- ☐ Cramps/Backache
- ☐ Irregular Cycle
- ☐ Painful Menstruation

Childhood trauma, surgeries, illnesses?_____

How many servings of coffee/red bull/caffeine/day? _____How many servings of alcohol/day?_____

Do you smoke &/or vape? _____How often? _____

Do you exercise regularly? Describe:_____

Do you sleep on your stomach?_____Mattress age?_____ Comfortable? ☐ YES ☐ NO

Is this condition related to a motor vehicle or work accident? _____

Do you have a pacemaker or other electronic device? _____

List all surgical operations and years: _____
_____
_____

List all drugs/medications/supplements you're currently taking _____
_____
_____

Any other health conditions/diagnosis, concerns we should know about? _____
_____
_____

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; this information about your family members will give us a better picture of your total health picture).

FAMILY MEMBER	**Health Conditions i.e. strokes, high blood pressure, cancer, diabetes, back pain, arm/leg pain, allergies etc**
MOTHER	
FATHER	
BROTHERS	
SISTERS	
CHILDREN	
GRANDPARENTS	

INDICATE THE TYPE AND LOCATION OF SENSATIONS YOU ARE EXPERIENCING RIGHT NOW

Please indicate all locations of the sensations you are experiencing right now, as well as the type of sensation (including aches, stabbing, pins and needles, numbness, burning or other sensations)

Please list any other symptoms

1.

2.

3.

4.

5.

CHIROPRACTIC CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and massage therapy, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic associated with Fitchett Chiropractic, including the doctors at the clinic or office listed below or any other office or clinic associated with Fitchett Chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the fact then known, is in my best interest. Alternative treatments may include: medication, surgery, or physical therapy procedures. As with any of these alternative procedures there are risks. If no treatment is sought, you condition could get worse, remain the same, or improve.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my condition.

_____ _____

Patient's Name (please print) Date Doctor's signature Date

_____

Signature of Patient or Legal Guardian & printed name, with relationship, if applicable

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Fitchett Chiropractic Center (FCC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to FCC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. FCC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to FCC Privacy Officer, PO Box 207, Kennett Square, PA 19348.

With my consent, FCC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, FCC may send mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that FCC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to FCC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Patient's Name (please print) Date

I also authorize FCC to release PHI to:

_____ _____

Signature of Patient or Legal Guardian Name Relationship

_____ _____

Print Name of Legal Guardian, if applicable Name Relationship