Uthoff Family Chiropractic, P.C.

606 39th Ave., Amana IA 52203 Tel:(319)622-3322

PATIENT CASE HISTORY:

First Name_____MI_____Last Name_____Nickname_____
Address_____City_____State_____Zip_____
Social Security #_____Date of Birth_____Sex: M /F Marital Status S M D W
Spouse/Parent_____Insurance Holder's Date of Birth_____
Cell #_____Home #_____ Work #_____
Emergency Contact_____ Relationship_____ Phone No._____
Your Employer_____ Occupation_____
Referred By: Patient, Name _____ How did you hear about our clinic?_____

What Insurance Carrier will you be using? ☐ **No Insurance** – I will be "Time of Service"

☐ **Primary** Insurance Card Name: _____ ☐ **Secondary** Insurance Card Name: _____

Reason for today's visit? _____
Present condition due to an injury? __Yes __No __ Work Comp. __ Auto Accident __Other_____
Has the accident been reported? __ Yes __ No ___ To Employer ___ Auto Carrier ___Other_____

GENERAL INFORMATION:

Have you ever had a chiropractic adjustment? Y/N If Yes, when was the last date of care? _____
Who was your last Chiropractic physician? _____

Have you been in an auto accident? ☐Yes ☐No If Yes, when? _____

Any other type of accident or fall? _____

Have you ever: ☐Been knocked unconscious? ☐Broken a Bone? _____

Have been treated for a spine or nerve disorder? If so, when?_____
List any other conditions/major surgeries:_____

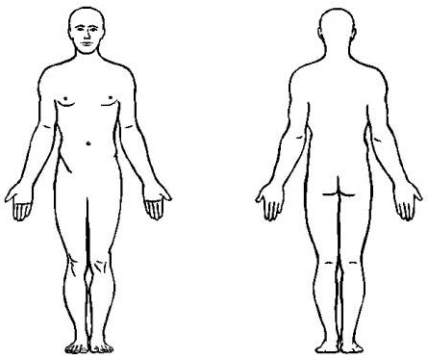
HEALTH REPORT:

Location of Complaint:_____
What was the initial cause of this complaint?_____
When did this complaint begin?_____
Are you presently under a doctor's care for this complaint? Y/N Doctors name:_____

Please check the Symptoms of the complaint/pain: ☐Dull ☐Aching ☐Sharp ☐Shooting ☐Burning
☐Deep ☐Throbbing ☐Nagging ☐Spasm ☐Numbness/Tingling ☐Other_____

Does this complaint/pain radiate or travel (shoot) to other areas of your body? Y/N Where?_____
Do you have any numbness or tingling in your body? Y/N Where?_____

Please mark on the picture where you feel pain…



Please circle degree of complaint/pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10

What activities **aggravate** your condition/pain?_____
_____

What activities **lessen** your condition/pain?_____
_____

Is this condition progressively getting worse? _____
Is this condition interfering with:
___ Work ___ Sleep ___ Activities ___Other?_____

HEALTH HISTORY:

List all medications that you regularly take, including prescriptions, over the counter medications:_____

_____

_____

List conditions you are taking medication for:_____

_____

Have you taken medication in the past? Y/N Please list medications:_____

_____

Do you take any Vitamins/Supplements Y/N If yes, type and how often_____

_____

Do **you** now have, or have you ever had the following diseases or conditions? (Please check below)

High Blood Pressure	___ Yes ___No	Shortness of breath	___ Yes ___No
Heart attack	___ Yes ___No	Emphysema	___ Yes ___No
Chest pain	___ Yes ___No	Asthma	___ Yes ___No
Heart murmur	___ Yes ___No	Chronic cough	___ Yes ___No
Irregular heartbeat	___ Yes ___No	Dizziness	___ Yes ___No
Artificial heart valve	___ Yes ___No	Wheezing	___ Yes ___No
Stroke	___ Yes ___No	Blood Clots	___ Yes ___No
Diabetes Type I / II	___ Yes ___No	Thyroid disease	___ Yes ___No
Kidney Disease	___ Yes ___No	Seasonal allergies	___ Yes ___No
Cancer	___ Yes ___No	Bleeding disorder	___ Yes ___No
Epilepsy/seizure	___ Yes ___No	Gastrointestinal disease	___ Yes ___No
Arthritis	___ Yes ___No	Liver disease/Hepatitis	___ Yes ___No
Mental illness	___ Yes ___No	Artificial joints:_____	___ Yes ___No
High Cholesterol	___ Yes ___No	AIDs/HIV	___ Yes ___No
Arteriosclerosis	___ Yes ___No		

Do you have a pacemaker or implanted defibrillator? ___Yes ___No

List any other conditions *not* listed above:_____

Social and Occupational History:

Job Description:

_____

Recreational Activities:

_____

Do you smoke? Y/N or use Tabaco? Y/N •Alcohol Y/N __Daily __Weekly __Social Occasions

Caffeinated drinks per day _____

FOR WOMEN ONLY

__ Birth Control _____	__ Irregular Cycle	Pregnant at this Time? ☐Yes ☐No
__ Hormone Replacement	__ Miscarriage	
__ Cramps/Backaches	__ Painful Periods	
__ Excessive Flow\	__ Vaginal Discharge	
__ Hot Flashes	__ Breast Pain	

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Completed by: ☐Patient ☐Family member

Patient/Guardian Signature _____

Please provide a staff member with a copy of your insurance card(s) and let us know if there is any changes in coverage!

Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We would be happy to provide you with a copy of the entire HIPAA practices of this office upon your request. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms for my primary insurance carrier to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me (and/or minor family members) are charged directly to me and that I am personally responsible for payment. I have read the above and agree to abide by the policies of this office.

Patient/Guardian Signature_____ **Date**_____