Chiropractic Case History

Name_____Sex M F
Date_____

Address_____City
_____State_____Zip_____

H/C. Phone(_____)_____W. Phone_____ Date of
Birth_____ Age_____

Referred by_____ Email
_____

Occupation_____ Employer_____
_____

Have you ever received Chiropractic Care? Yes No If yes, when?
_____

1. Primary reasons for seeking chiropractic care:

Primary reason:
_____
____

Secondary reason:
_____
__

Other factors contributing to the primary and secondary reasons:
_____

2. Chief Complaint:
_____

Location of Complaint:
_____

Complaint Began when and how?
_____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?
_____

Do you have any numbness or tingling in your body? Where?
_____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible

pain/complaint imaginable)

How frequent is complaint present, how long does it last?
_____

Does anything aggravate the complaint?
_____

Does anything make the complaint better?
_____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:
_____

_____
_____

_____
_____

4. Past Health History:

A. Previous illnesses you've had in your life:
_____

_____
_____

B. Previous injury or trauma:_____

_____
_____

Have you ever broken any bones? Which?
_____

C. Allergies
_____
_____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____

_____ _____
_____

_____ _____
_____

F. Females/ Pregnancies and outcomes:
Pregnancies/Date of Delivery Outcome
_____ _____
_____

_____ _____
_____

_____ _____
_____

What was the date of the beginning of your last menstrual period?
_____

5. Family Health History:
Associated health problems of relatives:
_____

_____
_____
Deaths in immediate family:
Cause of parents or siblings death Age at death
_____ _____
_____

_____ _____
_____

_____ _____
_____

6. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description:
_____
___

C. Work schedule:
_____
___

D. Recreational activities:
_____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

SELVAGGI CHIROPRACTIC

Selvaggi Chiropractic of Romeo
143 W. St. Clair St.
Romeo, Mi 48065
(586) 752-1515

Informed Consent

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____ Robert Selvaggi D.C.

Date:

Date:_____