Chiropractic Case History/Patient Information

Date:_____ Patient #_____
(Assigned by Office)

Last Name:_____ First Name:_____

Preferred Name/Nickname (if different):_____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Phone #:_____

Would you like to receive text message reminders for wellness appointments? ☐ Yes ☐ No

If yes: Cell # (if different) _____ Cell Service Provider: _____

Date of Birth:_____ Height: _____ Weight_____ Age:_____ Marital Status: M S W D

Occupation:_____ Employer:_____

Spouse:_____ Spouse's Employer:_____

Name of Emergency Contact:_____ Emergency Contact's 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? ☐ Yes ☐ No

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:

Name:_____ Relationship to self:_____

Name:_____ Relationship to self:_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ 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:_____

_____

Have you previously seen a chiropractor? □ Yes □ No If yes, who, when, and describe: _____

_____

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 of any kind? □ Yes □ No Medication Allergies? □ Yes □ No

If yes, describe:_____

_____

Do you have any Congenital Condition? □ Yes □ No If Yes, Describe _____

Women: Are you currently pregnant? _____ Number of previous pregnancies: _____

SOCIAL HISTORY

Exercise: □ None □ A little □ Often □ Daily

Alcohol Use: □ Yes □ No Approximate number of drinks per week: _____

Tobacco Use: □ Yes □ No Smoke: □ Yes □ No Amount per day: _____

Caffeine Consumption: □ Yes □ No Approximate amount daily:_____

Energy Drinks? □ Yes □ No Frequency:_____

Is there anything else you would like the Doctors to know? _____

_____

_____

_____

Do you Currently have, have you Previously, or has a Family Member been affected by the following conditions/symptoms. Please mark all boxes that apply.

	Currently	Previously	Family Member
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Bladder/Bowel Incontinence	☐	☐	☐
Cancer	☐	☐	☐
Chest Pain/Tightness	☐	☐	☐
Chronic Fatigue	☐	☐	☐
Circulation Problems (i.e. Cold Hands/Feet)	☐	☐	☐
Depression	☐	☐	☐
Diabetes	☐	☐	☐
Difficulty Urinating	☐	☐	☐
Dizziness/Vertigo/Fainting	☐	☐	☐
Drug/Alcohol Addiction	☐	☐	☐
Emphysema/COPD	☐	☐	☐
Extreme Weight Loss/Gain	☐	☐	☐
Fibromyalgia	☐	☐	☐
Frequent Colds/Fevers	☐	☐	☐
Heart Trouble/Disease	☐	☐	☐
High/Low Blood Pressure	☐	☐	☐
HIV Positive	☐	☐	☐
Insomnia	☐	☐	☐
Joint Pain/Swelling	☐	☐	☐
Kidney Trouble	☐	☐	☐
Liver Trouble	☐	☐	☐
Lung/Breathing Issues	☐	☐	☐
Migraines	☐	☐	☐
Nervousness/Anxiety	☐	☐	☐
Neuritis/Neuropathy	☐	☐	☐
Numbness in Hands/Feet	☐	☐	☐
Osteoporosis	☐	☐	☐
Pinched Nerve	☐	☐	☐
Scoliosis	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐
Stomach Trouble	☐	☐	☐

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____