CHIROPRACTIC CASE HISTORY/PATIENT INFORMATION

Date: _____ Patient #: _____ Doctor: _____

Name: _____ _ Social Security #: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail address: _____ Fax #: _____ Cell Phone: _____
Age: _____ Birth Date: _____ Race: _____ Marital: M S W D
Occupation: _____ Employer: _____
Employer's Address: _____ Office Phone: _____
Spouse: _____ Occupation: _____ Employer: _____
How many children? _____ Names and Ages of Children: _____
_____
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: _____
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 payers 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.

This 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: _____

PATIENT NAME: _____
DATE: _____ **DOCTOR: _____**

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 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? Women, please include information about childbirth (includes dates): _____
_____
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 Congenial 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: _____

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

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulations 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	_____	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	_____