Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:** Kroneck

Name:_____ Home Phone: _____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ E-mail address:_____

Age:_____ Birth Date:_____ Gender: M F Marital Status: M S W D How many children? _____

Occupation:_____ Employer:_____ Office Phone:_____

Spouse:_____ Emergency Contact Name:_____ 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

PAST MEDICAL HISTORY

Have you ever suffered from:

☐ Asthma	☐ Diabetes	☐ Digestive Disorders	☐ Numbness	☐ Rheumatoid Arthritis	
☐ Allergies	☐ Depression	☐ Dizziness	☐ Stroke	☐ Sinus Trouble	☐ Cancer
☐ Back Pain	☐ Arthritis	☐ Heart Trouble	☐ Epilepsy	☐ Headaches	☐ Pace Maker

What medications or drugs are you taking?_____

_____

HEALTH HABITS

How many cups of **water** do you drink each day? ____ **Coffee:**____ **Soda:**____ **Milk:**____ **Tea:**____ **Other:**____

Average number of **alcoholic drinks** per week: ____

Circle **tobacco** use: Cigarettes Cigar Chew Pipe How many per day? _____ How long? ____ years

How often do you have a **bowel movement**? _____ per day If not daily: ____ per week If not weekly: ____ per month

What percent of your diet is **raw fruit and raw vegetables**? _____ %

Do you take **vitamin supplements**? ☐ Yes ☐ No If so, please list:_____

Do you **exercise**? ☐ Yes ☐ No If yes, what type of exercise and frequency?_____

What are your **hobbies**?_____

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. I understand that interest is charged on overdue accounts at the annual rate of 12%.

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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

- (Over) -

Summary of Present Illness

Name:_____ Date:_____

*** * *Please place an "X" on the line below to indicate severity of problem.* * ***

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

1. **Type of Problem(s)**: ☐ Low Back Pain ☐ Mid Back Pain ☐ Upper Back Pain ☐ Neck Pain
   ☐ Shoulder Pain ☐ Wrist/Hand Pain ☐ Hip Pain ☐ Knee Pain ☐ Foot/Ankle Pain ☐ Headaches
   ☐ Fibromyalgia ☐ Dizziness ☐ Sciatica ☐ Other: _____
2. **How long** have you had this problem?_____
   How did it **occur**?_____
   Has this problem been: ☐ Staying the Same ☐ Getting Better ☐ Getting Worse
3. How **frequent** is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only
   How **long does it last**? ☐ All Day ☐ Few Hours ☐ Minutes
4. Describe the **pain**: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing
   ☐ Other _____
5. What **makes the problem worse**? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting
   ☐ Other _____
6. Have you sought **any other care** for this condition? ☐ Yes ☐ No If yes, describe _____
   _____
   What has been done for this problem? ☐ X-rays ☐ MRI ☐ Medication ☐ Injections ☐ Physical Therapy
7. Is there **anything** you can do to **relieve the problem**? ☐ Yes ☐ No If yes, describe _____
   _____
8. Do you have any other **unrelated health problems**? ☐ Yes ☐ No If yes, describe _____
   _____
9. List any **major accidents** you have had other than those mentioned above: _____
   _____
10. What does this **prevent you from doing or enjoying**?_____
11. List the date and any **surgeries** you have had: _____
    _____
12. Have you been to a **chiropractor before**? ☐ Yes ☐ No When? _____
    Doctor's Name and location: _____
13. **Women Only**: Are you **pregnant** or is there any possibility you may be pregnant? ☐ Yes ☐ No ☐ Uncertain
14. Dr. Remarks: _____
    _____
    _____
    _____
    _____
    _____

Doctor's Signature _____ Date _____