

Chiropractic Case History/Patient Information

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

Name: _____ **Social Security #** _____ **Home Phone:** _____

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

E-mail address: _____ **Cell Phone:** _____

Age: _____ **Birth Date:** _____ **Race:** _____ **Marital:** M S W D **Gender:** M F

Occupation: _____ **Employer:** _____

Employer's Address: _____ **Office Phone:** _____

Spouse: _____ **Occupation:** _____ **Employer:** _____

How many dependents? _____ **Names and Ages:** _____

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

Please check method of payment you wish to utilize for services rendered

- cash
- check
- credit card (visa, mastercard, discover)
- care credit

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:

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 a similar condition? π Yes π 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 (include dates): _____

Have you been treated for any health condition by a physician in the last year? π Yes π No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? π Yes π No

If yes, describe: _____

Do you have any allergies of any kind? π Yes π No

If yes, describe: _____

Do you have any Congenital 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 **C** if you are **currently** experiencing these conditions or **P** if you have had these conditions **previously**.

C = Currently

P = Previously

Headaches _____ Frequency _____

Neck Pain _____

Stiff Neck _____

Sleeping Problems _____

Back Pain _____

Nervousness _____

Tension _____

Irritability _____

Chest Pains/Tightness _____

Dizziness _____

Loss of Balance _____

Fainting _____

Loss of Smell _____

Loss of Taste _____

Unusual Bowel Patterns _____

Feet Cold _____

Hands Cold _____

Arthritis _____

Muscle Spasms _____

Frequent Colds _____

PATIENT NAME _____

DATE _____

Doctor _____

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	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation 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	_____ Caffeine	_____ Other (Please Specify)
_____ Moderate Exercise	_____ High Stress Activity	_____
_____ Alcohol Use	_____ Family Pressures	_____
_____ Drug Use	_____ Financial Pressures	
_____ Tobacco Use	_____ Other Mental Stresses	

TIME PREFERENCES

Please indicate which times would be best for you to schedule future appointments. Mark all possible times that fit your schedule

	Mon	Tues	Wed	Thurs	Fri
10:00 - 11:00					
11:00 - 12:00					
12:00 - 1:00					
1:00 - 2:00	-----	-----	-----	-----	
2:00 - 3:00					-----
3:00 - 4:00					-----
4:00 - 5:00					-----
5:00 - 6:00					-----

PATIENT NAME _____

DATE _____

Doctor _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)	SISTERS	CHILDREN
	Age []	Age []	Age []	Age [] Age []	Age [] Age []	Age [] Age []
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____