

Chiropractic Case History/Patient Information

Date: _____ Patient # _____ Doctor: _____

Name: _____ Social Security # _____ Birth Date: _____

Hm Phone: _____ Wk Ph: _____ Cell: _____

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

E-mail address: _____ Fax # _____

Age: _____ Sex M / F Race: _____ Marital: M S W D

How many children? _____ Names and Ages of Children: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Spouse: _____ Occupation: _____ Employer: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

How were you referred to our office? _____

Family Doctor: _____ Dentist _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Y / N

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:](#)

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 **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now

P = Previously

Headaches_____ Frequency _____
 Neck Pain _____
 Stiff Neck _____
 Sleeping Problems _____
 Back Pain _____
 Nervousness _____
 Tension _____
 Irritability _____
 Chest Pains/Tightness _____
 Dizziness _____
 Shoulder/Neck/Arm Pain _____
 Numbness in Fingers _____
 Numbness in Toes _____
 High Blood Pressure _____
 Difficulty Urinating _____
 Weakness in Extremities _____

Loss of Balance _____
 Fainting _____
 Loss of Smell _____
 Loss of Taste _____
 Unusual Bowel Patterns _____
 Feet Cold _____
 Hands Cold _____
 Arthritis _____
 Muscle Spasms _____
 Frequent Colds _____
 Fever _____
 Sinus Problems _____
 Diabetes _____
 Indigestion Problems _____
 Joint Pain/Swelling _____
 Menstrual Difficulties _____

PATIENT NAME _____

DATE _____

Doctor _____

Breathing Problems _____
 Fatigue _____
 Lights Bother Eyes _____
 Ears Ring _____
 Broken Bones/Fractures _____
 Rheumatoid Arthritis _____
 Excessive Bleeding _____
 Osteoarthritis _____
 Pacemaker _____
 Stroke _____
 Ruptures _____
 Eating Disorder _____
 Drug Addiction _____
 Gall Bladder Problems _____
 Ulcers _____

Weight Loss/Gain _____
 Depression _____
 Loss of Memory _____
 Buzzing in Ears _____
 Circulation Problems _____
 Seizures/Epilepsy _____
 Low Blood Pressure _____
 Osteoporosis _____
 Heart Disease _____
 Cancer _____
 Coughing Blood _____
 Alcoholism _____
 HIV Positive _____
 Depression _____

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

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 | | | | | | | | | |
| High Blood 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 _____