Chiropractic Case History/Patient Information

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

Name:_____ Social Security #_____

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

E-mail address: _____ Fax #_____ Home/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: _____ 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 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:

_____

_____

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

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? ☐ 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 (include 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 or anything else? ☐ Yes ☐ No

If yes, describe:_____

Do you have any artificial implants of any kind? ☐ Yes ☐ 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		Loss of Balance		Breathing Problems		Weight Loss/Gain	
Neck Pain		Fainting		Fatigue		Depression	
Stiff Neck		Loss of smell		Lights Bother Eyes		Loss of Memory	
Sleeping Problems		Loss of taste		Ears Ring		Buzzing in Ears	
Back Pain		Unusual Bowel Patterns		Broken Bones/Fractures		Circulation Problems	
Nervousness		Cold feet		Rheumatoid Arthritis		Seizures/Epilepsy	
Tension		Cold hands		Excessive Bleeding		Low Blood Pressure	
Irritability		Arthritis		Osteoarthritis		Osteoporosis	
Chest Pains/Tightness		Muscle Spasms		Pacemaker		Heart Disease	
Dizziness		Frequent Colds		Stroke		Cancer	
Shoulder/Neck/Arm Pain		Fever		Ruptures		Coughing Blood	
Numbness in Fingers		Sinus Problems		Eating Disorder		Alcoholism	
Numbness in Toes		Diabetes		Drug Addiction		HIV Positive	
High Blood Pressure		Indigestion Problems		Gall Bladder Problems		Depression	
Difficulty Urinating		Joint Pain/Swelling		Ulcers			
Weakness in Extremities		Menstrual Difficulties					