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: Married Single Widowed Divorced

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?_____

HISTORY OF PRESENT 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:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (check the conditions that apply to you)

☐ Broken/Fractured Bones	☐ Low Blood Pressure	☐ Eating Disorder	☐ Coughing up blood
☐ Circulatory Problems	☐ Congenital Disease	☐ Alcoholism	☐ Measles
☐ Rheumatoid Arthritis	☐ Epilepsy	☐ Drug Addiction	☐ Mumps
☐ Osteoarthritis	☐ Pace Maker	☐ HIV Positive	☐ Chicken Pox
☐ Seizures/Convulsions	☐ Strokes	☐ Gall Bladder	☐ Childhood Diseases
☐ Excessive Bleeding	☐ Cancer	☐ Depression	_____
☐ High Blood Pressure	☐ Ruptures	☐ Ulcers	_____
☐ Headaches	☐ Shoulder/Neck/Arm Pain	☐ Fainting	☐ Diabetes
☐ Neck Pain	☐ Numbness in Fingers	☐ Loss of Smell	☐ Indigestion Problems
☐ Stiff Neck	☐ Numbness in Toes	☐ Loss of Taste	☐ Joint Pain/Swelling
☐ Sleeping Problems	☐ Difficulty Urinating	☐ Unusual Bowel Patterns	☐ Menstrual Difficulties
☐ Back Pain	☐ Weakness in Extremities	☐ Cold Feet	☐ Weight Loss/Gain
☐ Nervousness	☐ Breathing Problems	☐ Cold Hands	☐ Depression
☐ Tension	☐ Fatigue	☐ Muscle Spasms	☐ Loss of Memory
☐ Irritability	☐ Lights Bother yes	☐ Frequent Colds	☐ Buzzing in Ears
☐ Chest Pains/Tightness	☐ Ears Ringing	☐ Fever	☐ Women: Are you currently
☐ Dizziness	☐ Loss of Balance	☐ Sinus Problems	pregnant?

Have you had any:

Major illnesses ☐ No ☐ Yes Describe _____

Hospitalizations or Surgeries ☐ No ☐ Yes Describe _____

Injuries ☐ No ☐ Yes Describe _____

Falls ☐ No ☐ Yes Describe _____

Auto accidents ☐ No ☐ Yes Describe and Date _____

Women, Number or Births_____ and delivery method (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 of any kind? ☐ Yes ☐ No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you take drugs? _____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____
What is your typical stress level?_____

FAMILY HISTORY:

Parents:
Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____

Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

☐ Tuberculosis	☐ Heart Disease	☐ Insomnia
☐ Diabetes	☐ Lung Disease	☐ Migraine
☐ Stroke	☐ Back Trouble	☐ Nervousness
☐ Arthritis	☐ Bursitis	☐ Neuritis
☐ Cancer	☐ Constipation	☐ Neuralgia
☐ Asthma	☐ Disc Problem	☐ Pinched Nerve
☐ Hay Fever	☐ Emphysema	☐ Scoliosis
☐ Kidney Disaese	☐ Epilepsy	☐ Sinus Trouble
☐ Liver Disease	☐ Headaches	☐ Stomach Trouble
☐ Mental Illness	☐ High Blood Pressure	☐ Other _____

INFORMED CONSENT TO TREAT: I understand and am informed that, in the practice of chiropractic medicine there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that I may revoke this consent at anytime verbally or in writing to the doctor. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures outlined by my doctor of chiropractic in my treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

~~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. 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:_____