

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: 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: _____ 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 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? 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? Yes No

If yes, describe: _____

Do you have any allergies 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_____ 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
- _____ Moderate Exercise
- _____ Alcohol Use
- _____ Drug Use
- _____ Tobacco Use
- _____ Caffeine
- _____ High Stress Activity

- _____ Family Pressures
- _____ Financial Pressures
- _____ Other Mental Stresses
- _____ Other (specify) _____
- _____
- _____

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 _____