CHIROPRACTIC CASE HISTORY / PATIENT INFORMATION

DATE: _______________ Patient #: _________________ Doctor: ______________

Name: ___________________________ Social Security #: ______________________ Home Phone: _______________

Address: ____________________________ City: ____________________ State: __________________ Zip: ____________

E-mail: ________________________________ Fax #: _____________________ Cell #:______________________________

Age: ________ Birth Date: _______________ Marital Status (circle one): M S W D How many children? _________

Occupation: _____________________________________ Employer: ____

Employer's Address: ____ Employer Phone: ___________________________

Name of nearest relative: _____________________________ Address: ____

Phone: ____________________

How were you referred to our office? ____

Family Medical Doctor: ____

Purpose of this appointment? ____

Date symptoms appeared or accident happened: ____

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: _________________

Serious illnesses / Surgeries (include dates): ____

____

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

If yes describe: ____

Please check and all insurance coverage that may be applicable in this case:

Major Medical ____ Worker's Compensation ____ Medicaid ____ Medicare ____ Auto Accident ____ Other ____

Name of Primary Insurance Company: ____

Name of Secondary Insurance Company: ____

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 payers 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. I understand that interest is charged on overdue accounts at the annual rate of 16.

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 ant 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 more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to rad the HIPPAA 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: __________

1. What is your major symptom? ____
2. What does this prevent you from doing or enjoying? ___________________________________

   ____
3. If this is a recurrence, when was the first time you noticed this problem? N/A ______________

   How did it originally occur? ____

   Has it become worse recently? Yes ____ No ____ Same ____ Better ____ Gradually Worse ____

   If yes, how and when? ____
4. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only ____

   How long does it last? All Day _____ Few hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____ If yes describe: ____
6. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other: ____
7. What makes the problem worse: Standing ____ Sitting ____ Lying ____ Bending ____

   Lifting ____ Twisting ____ Other:____
8. Is there anything that you can do to relieve the problem: Medication ____ Stretching ____

   Exercise ____ Laying ____ Resting ____ Sitting ____ Cold ____ Heat ____ Massage ____

   What have you tried that has not helped? _______________________________________
9. Have you had any broken bones? Yes ____ No ____ If yes please list and explain: ___________

   ____
10. Do you exercise? Yes _____ No _____ If yes, what forms? _____________________________
11. **WOMEN ONLY:** Are you pregnant or is there any possibility you may be pregnant?

    Yes: ______ No:______ Uncertain: ______
12. Remarks:

    ____

    ____

    ____

Please Answer

No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Please circle the number on the line above to indicate pain level

Doctor's Signature: ____________________________

Date: _____________________