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 How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone_____

Spouse _____ Occupation _____ Employer_____

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 _____ What surgeries have you had? (Include dates) _____

_____

Serious illnesses (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? _____

_____

Please check any 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 (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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%.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

1. What is your major symptom? _____

2. If this is a recurrence, when was the first time you noticed this problem? _____

   How did it originally occur? _____

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

   If yes, when and how? _____

3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

   How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that may be related to your major symptom?

   Yes _____ No _____. If yes, describe _____

   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

5. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other _____

6. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____

   _____. If no, what have you tried to do that has not helped? _____

   _____

7. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

   Lifting _____ Twisting _____ Other _____

8. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____

   _____

9. List any major accidents you have had other than those that might be mentioned above: _____

   _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____

    _____

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

12. Remarks: _____

    _____

    _____

NO SYMPTOMS — EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

Doctor's Signature _____ Date _____

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 Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN 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 _____

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 _____

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 _____

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 _____

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