

Patient \_\_\_\_\_ Date \_\_\_\_\_

(1)

## Chiropractic Case History/Patient Information

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone# \_\_\_\_\_ Cell# \_\_\_\_\_

E-mail address \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Marital: M S W D #of 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 \_\_\_\_\_ Phone# \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_

Date Symptoms appeared or accident happened \_\_\_\_\_

Have you ever had the same or similar condition? \_\_\_ Yes \_\_\_ No if yes, when and describe: \_\_\_\_\_

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Days lost from work \_\_\_\_\_ Date of last Physical Exam \_\_\_\_\_ Previous Surgeries (include dates) \_\_\_\_\_

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Serious illnesses (include dates) \_\_\_\_\_

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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? \_\_\_\_\_

What is your major symptom? \_\_\_\_\_

What does this prevent you from doing or enjoying? \_\_\_\_\_

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? \_\_\_\_\_

How frequent is the condition? \_\_\_ all day \_\_\_ few hours \_\_\_ Minutes

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 \_\_\_\_\_

Describe the pain: \_\_\_ sharp \_\_\_ dull \_\_\_ numbness \_\_\_ tingling \_\_\_ aching \_\_\_ burning

\_\_\_ stabbing \_\_\_ other \_\_\_\_\_

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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?  
\_\_\_\_\_

What makes the problem worse? \_\_\_standing \_\_\_sitting \_\_\_lying \_\_\_bending \_\_\_lifting  
\_\_\_twisting \_\_\_other \_\_\_\_\_

Have you had any broken bones? \_\_\_yes \_\_\_no. if yes, please list and give dates \_\_\_\_\_

List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in the case.

\_\_\_Major Medical \_\_\_Workers Compensation \_\_\_Medicaid \_\_\_Medicare \_\_\_Auto Accident  
\_\_\_Other \_\_\_Medical Savings account & Flex Plans

Name of *Primary* Insurance Company \_\_\_\_\_

Name of *Secondary* Insurance Company \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiroprator 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 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 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 \_\_\_\_\_