

# 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? \_\_\_\_\_

## 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? (Place a check mark by conditions that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Ulcers

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: \_\_\_\_\_

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 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 \_\_\_\_\_

**FAMILY HISTORY:**

Parents:  
Father: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_ (check one)

Mother: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_ (check one)

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

Do you have any family members who suffer from the same condition you do? If so, please list: \_\_\_\_\_

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

Tuberculosis \_\_\_ Cancer \_\_\_ Mental Illness \_\_\_  
Diabetes \_\_\_ Asthma \_\_\_ Heart Disease \_\_\_  
Stroke \_\_\_ Kidney Disease \_\_\_ Lung Disease \_\_\_  
Arthritis \_\_\_ Liver Disease \_\_\_  
Other \_\_\_\_\_

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

- Major Medical  Worker's Compensation  Medicaid  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. 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: \_\_\_\_\_

SUMMARY

- 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? \_\_\_\_\_  
How did it originally occur? \_\_\_\_\_  
Has it become worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually Worse \_\_\_  
If yes, when and how? \_\_\_\_\_
- 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: \_\_\_\_\_  
Are there other unrelated health problems? Yes \_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_
- 6. Describe the pain: Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_  
Burning \_\_\_ Stabbing \_\_\_ Other \_\_\_\_\_
- 7. 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? \_\_\_\_\_  
\_\_\_\_\_
- 8. What makes the problem worse? Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending \_\_\_  
Lifting \_\_\_ Twisting \_\_\_ Other \_\_\_\_\_
- 9. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_  
\_\_\_\_\_
- 10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  
Yes \_\_\_ No \_\_\_ Uncertain \_\_\_\_\_
- 11. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

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

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_