

# 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 Father, Mother, Sister, Brother):

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. Have you received any treatment for this condition? Yes\_\_\_ No\_\_\_ If yes, where and when, and what  
were your results? \_\_\_\_\_
11. Any Medical Diagnosis of your complaint? \_\_\_\_\_
12. Any Chiropractor consulted in past? Name \_\_\_\_\_ when? \_\_\_\_\_
13. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Uncertain \_\_\_\_\_
14. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

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

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Use Only**

- 1
- 4-5
- >5

Patient #: \_\_\_\_\_

# Pain Drawing

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Examiner: \_\_\_\_\_

## TELL US WHERE YOU HURT.

**Please read carefully:**

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>>

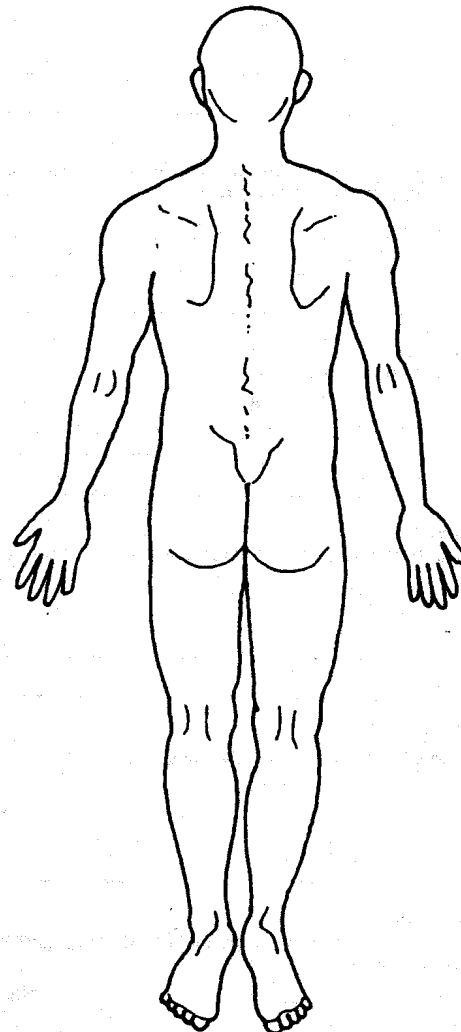
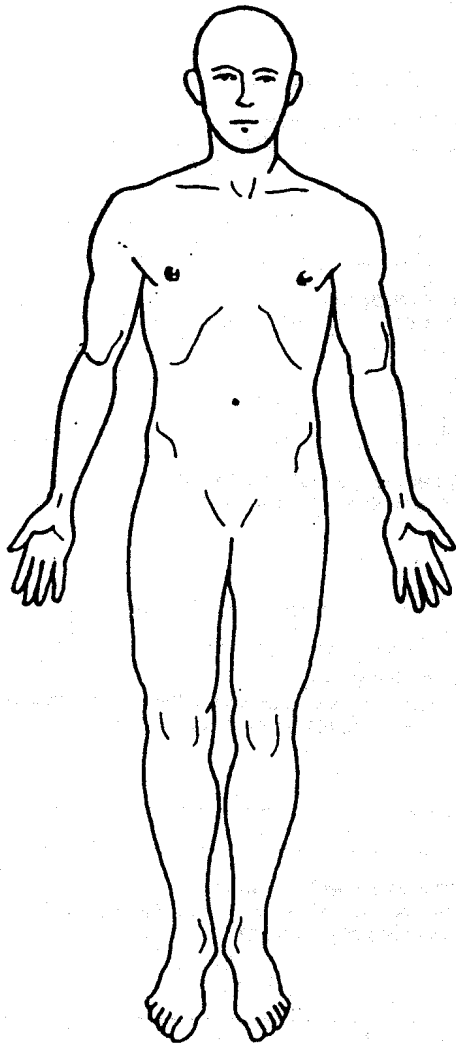
Burning x x x x

Numbness = = = = =

Stabbing / / / / /

Pins & Needles o o o o

Throbbing ~ ~ ~ ~ ~



## Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient

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Date

*For further information regarding this notice, please contact our Doctor at (770)-562-8590*