



PATIENT INFORMATION AND CHIROPRACTIC CASE HISTORY

Date Patient #

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 Name Occupation Employer

Name of Nearest Relative Address Phone

How did you find out about us? Referral Ad Website Health Fair Other

Family/Personal Medical Doctor Date of last physical examination

Purpose of this appointment

Date symptoms appeared or accident happened Days lost from work

Have you ever had the same or a similar condition? Yes No If yes, when and describe:

What surgeries have you had (if any)? (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 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. I understand that interest is charged on overdue accounts at the annual rate of 18%.

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. For 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

PHYSICAL CONDITION QUESTIONS

- What is your major symptom? _____
- 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? Constant Daily Intermittent Night Only
- How long does it last? 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 (describe) _____
- 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 (describe) _____
- 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: _____

- 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 _____

- WOMEN ONLY: Are you or may you be pregnant? Yes No Uncertain

Remarks:

NO
SYMPTOMS

EXTREME
SYMPTOMS

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

Doctor's Signature

Date