

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

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. [The following person\(s\) have my permission to receive my personal health information:](#)**

\_\_\_\_\_

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

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

**HISTORY OF PRESENT AND PAST 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: \_\_\_\_\_

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: \_\_\_\_\_

Do you have any Congenital Condition? \_\_\_Yes \_\_\_ No If YES, Describe \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_

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 _____	_____	Loss of Balance _____
Neck Pain _____	_____	Fainting _____
Stiff Neck _____	_____	Loss of Smell _____
Sleeping Problems _____	_____	Loss of Taste _____
Back Pain _____	_____	Unusual Bowel Patterns _____
Nervousness _____	_____	Feet Cold _____
Tension _____	_____	Hands Cold _____
Irritability _____	_____	Arthritis _____
Chest Pains/Tightness _____	_____	Muscle Spasms _____
Dizziness _____	_____	Frequent Colds _____
Shoulder/Neck/Arm Pain _____	_____	Fever _____
Numbness in Fingers _____	_____	Sinus Problems _____
Numbness in Toes _____	_____	Diabetes _____
High Blood Pressure _____	_____	Indigestion Problems _____
Difficulty Urinating _____	_____	Joint Pain/Swelling _____
Weakness in Extremities _____	_____	Menstrual Difficulties _____

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

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 \_\_\_\_\_

Weight Loss/Gain \_\_\_\_\_  
 Depression \_\_\_\_\_  
 Loss of Memory \_\_\_\_\_  
 Buzzing in Ears \_\_\_\_\_  
 Circulation Problems \_\_\_\_\_  
 Seizures/Epilepsy \_\_\_\_\_  
 Low Blood Pressure \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_  
 Heart Disease \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Coughing Blood \_\_\_\_\_  
 Alcoholism \_\_\_\_\_  
 HIV Positive \_\_\_\_\_  
 Depression \_\_\_\_\_

**SOCIAL HISTORY**

Please indicate beside each activity whether you engage in it:  
OFTEN= "O"    SOMETIMES= "S"    NEVER= "N"

\_\_\_\_\_ Vigorous Exercise

\_\_\_\_\_ Family Pressures

\_\_\_\_\_ Moderate Exercise

\_\_\_\_\_ Financial Pressures

\_\_\_\_\_ Alcohol Use

\_\_\_\_\_ Other Mental Stresses

\_\_\_\_\_ Drug Use

\_\_\_\_\_ Other (specify)\_\_\_\_\_

\_\_\_\_\_ Tobacco Use

\_\_\_\_\_

\_\_\_\_\_ Caffeine

\_\_\_\_\_

\_\_\_\_\_ High Stress Activity

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	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	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 \_\_\_\_\_