

Case History/Patient Information

Date _____

Last Name _____ Middle Initial _____ First _____

Social Security # ____/____/____ Home Phone (____) _____ Cell Phone (____) _____

Address _____ Fax (____) _____

City _____ State _____ Zip _____

E-mail address _____ Age _____ Birth Date ____/____/____

Gender: M F Race _____ Marital: M S W D How many children? _____

Occupation _____ Employer _____

Spouse _____ Occupation _____ Employer _____

How were you referred to our office? _____

Family Medical Doctor _____

Date symptoms appeared _____ Have you been to another healthcare provider for this condition? Yes No

If so where? _____

Are you off work now due to this condition? Yes No Total days lost from work _____

Date of last physical examination _____ What surgeries have you had? (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 Workers' Compensation 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 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 _____

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? Work Sleep Housework Family Activities Concentrate
 Mood General Activity Other _____
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 your symptoms: 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 Driving
 Walking Other _____
9. Have you had any broken bones? Yes No If yes, please list and give dates _____

10. List any major accidents you have had other than those that might be mentioned above: _____

11. 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 _____

12. What is your exercise frequency? daily 4-6 days/week 2-3 days/week 1-2 days/week none
13. What type of exercise do you perform? _____
14. Any other health concerns not addressed above: _____

15. Do you smoke? Yes No How many packs per day? _____ How long have you smoked? _____
16. Do you drink alcohol? Yes No How many drinks per week? _____
17. Women Only: Are you pregnant or is there any possibility you may be pregnant? Yes No Uncertain
18. What do you feel your overall function level is right now? _____% of normal

Family History: Check any diseases you or your relatives have had (if known):

Relationship	Spine Problems	Cancer	Diabetes	Heart Disease/ Stroke	Arthritis	Neurological Disease	Prostate Disease
Yourself							
Father							
Mother							
Brothers/Sister							
Grandparents							

Please describe the location and type of pain on the diagram below.

Mark the areas on the diagram with the appropriate symbols for the sensations that you feel. Include all affected areas.

Numbness

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Pins and Needles

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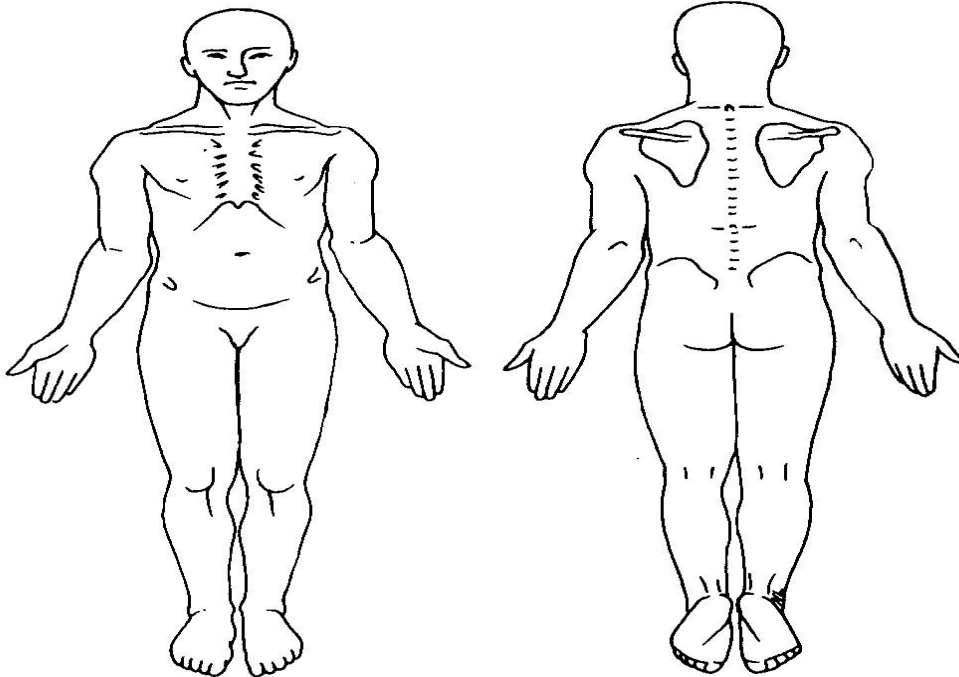
Burning

XXXX

Aching

Sharp/Stabbing

/////



NO SYMPTOMS

EXTREME SYMPTOMS



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