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 How many children? ________

Occupation ____________________________________ Employer ____________________________________

Employer's Address ____ Office Phone ________________

Spouse _____________ Occupation __________________ Employer __________________________________

Name of Nearest Relative ____________________________ Address ______________________ Phone __________

How were you referred to our office? ____

Family Medical Doctor ____

Purpose of this appointment ____

Date symptoms appeared or accident happened ____

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

____

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? π Yes π 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.

π Major Medical π Worker's Compensation π Medicaid

π Medicare π Auto Accident π 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 understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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%.

Patient's Signature ____ Date ____________

Guardian's Signature Authorizing Care ______________________________________ Date ____________

1. What is your major symptom? ____

2. 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? ____

3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

   How long does it last? All Day _________ Few Hours ___________ Minutes ______________

4. 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 __________

5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

   Burning _____ Stabbing _____ Other ____

6. 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? ______________

   ____

7. What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending _____

   Lifting _____ Twisting _____ Other ____

8. Does coughing, sneezing or straining for a bowel movement increase your pain? Yes ___ No ___

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. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

    Yes _____ No _____ Uncertain _____

13. Family Members who suffer from same/similar conditions: _______________________________

    ____

14. Remarks: ____

    ____

    ____

NO SYMPTOMS |____| EXTREME SYMPTOMS

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

Doctor’s Signature ____ Date _____________