Chiropractic Case History/Patient Information

Date:__________________

Name:______________________________Birth Date:_____________SS# ---------------------------- ____________

Address:_______________________________________City:_________________State:____Zip:____________

E-mail address: _ ______________________________May we send appointment reminders to this email?: Yes/No

Cell Phone:___________________Cell phone carrier:______________________(in order to send text reminders)

Home Phone:______________________Race:_______Marital: M S W D

Occupation:______________________

Spouse's Name (only required if this is your insurance policy holder):_____________________________________

How were you referred to our office?____

Family Medical Doctor (first and last name): ____

HISTORY OF PRESENT ILLNESS:

Chief Complaint (reason for 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 answered yes, when was this and describe the circumstances: ____________________________________

Any days lost from work?:_________________

Date of last physical examination:_________________________

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Please check)

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Excessive Bleeding
__High/Low Blood Pressure

_Osteoarthritis
__Epilepsy
__Pace Maker
__Strokes
__Cancer
__Ruptures
__Coughing Blood

_Eating Disorder
__Alcoholism
__Drug Addiction
__HIV Positive
__Gall Bladder
__Depression
__Ulcers

Have you had any major illnesses, injuries, falls, auto accidents, hospitalizations or surgeries? Women, please include information about childbirth (include dates): ____

____

Are you currently being treated for any chronic health conditions? _____Yes _____No

If yes,describe:____

What medications (including vitamins) are you currently taking?____

____

Do you have any allergies to any medications?____Yes_____No

If yes, describe:____

Do you have any allergies of any kind (i.e. seasonal, latex, etc.)?____Yes __No

If yes, describe:____

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 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?____

FAMILY HISTORY:
Parents:
Father: living____deceased_____(check one) Current age if still living:_______
Cause of death and age at death if deceased?:____

Mother: living____deceased_____(check one) Current age if still living:_______
Cause of death and age at death if deceased?:____

Check if applicable: _____As an adopted child, little is known of birth parents or family.

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis_____
Diabetes________
Stroke__________
Arthritis______

Cancer_____
Asthma_____
Kidney Disease_____
Liver Disease _____

Mental Illness_____
Heart Disease _____
Lung Disease_____
High Blood Pressure _____

Other ____

Please check any and all insurance coverage that may be applicable in this case**:**

____Major Medical_____Worker's Compensation_____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:__________________