

## Chiropractic Case History/Patient Information

Date \_\_\_\_\_ Information is strictly confidential and will never be released without your consent Patient # \_\_\_\_\_  
(first, middle initial, last)

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 \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

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: \_\_\_\_\_

Have you seen a chiropractor before?  Yes  No \_\_\_\_\_

Family Medical Doctor \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

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  Worker's Compensation  Medicaid Policy # \_\_\_\_\_

Medicare  Auto Accident  Other Group # \_\_\_\_\_

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 payers 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 \_\_\_\_\_

Name \_\_\_\_\_

1. What is your major symptom? \_\_\_\_\_  
What does this prevent you from doing or enjoying? \_\_\_\_\_
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. Have you had any broken bones? Yes \_\_\_ No \_\_\_\_\_. If yes, please list and give dates \_\_\_\_\_  
\_\_\_\_\_
9. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_  
\_\_\_\_\_
10. 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 \_\_\_\_\_  
\_\_\_\_\_
11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  
Yes \_\_\_ No \_\_\_ Uncertain \_\_\_\_\_
12. Remarks: \_\_\_\_\_  
\_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

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

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_