# Chiropractic Case History/Patient Information

*Please fill out the following form in as much detail as possible.* ***Please print.***

*Date:* _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Age: _____ Date of Birth: _____ Whom can we thank for referring you?_____

Primary Care Physician: _____ Telephone: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Are you currently working with a personal trainer? □ YES □ NO

*If yes,* please provide Trainer Name/Email/ Phone : _____

Is any other member of your family being treated in this office? □ YES □ NO

Have you ever had chiropractic care before? □ YES □ NO Were the results satisfactory? □ YES □ NO

*If yes,* For what problem? _____

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**INSURANCE INFORMATION:**

| | |
|---|---|
| Name of Insurance Co. | |
| Phone for Ins. Co. | |
| Subscriber Date of Birth | |
| Primary policy holder | |
| Claim/Group# | |
| Insured SS#/ID# | |
| Employer | |

**AUTHORIZATION, ASSIGNMENT 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 and am responsible for services not covered by my insurance. 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 monthly rate of 10%.

Patient's Signature:_____ Date:_____

**PRIVACY NOTICE POLICY:** Our privacy policy states that we will not disclose any HIPAA protected information to any person without a signed authorization from the patient. You may receive a copy of our privacy policies at your request

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.

Patient's Signature: _____ Date:_____

**PRESENTING PROBLEM**

Major complaints and symptoms — please be specific in describing what brings you in today:

_____

When did you first notice this problem/pain? _____

How do you believe this problem/pain began? _____

What daily activities have been affected?
□ sitting □ standing □ walking □ sleeping □ concentrating □ driving □ exercising □ other: _____

Have you seen anyone else for this problem? □ YES □ NO
*If yes:* Whom? _____ For how long? _____

Have you ever had this condition before? □YES □ NO
If, yes: when? _____

Do you have any allergies? □YES □ NO
*If yes*, please list _____

Have you had any previous surgeries? □ YES □ NO
*If yes*, please list _____

Are you presently taking any vitamins, herbs or other supplements? □ YES □ NO
*If yes*, please list _____

Are you presently taking any medications, either prescribed or OTC? □ YES □ NO
*If yes*, please list _____

Please list any other health concerns you wish to discuss: _____

**FAMILY HISTORY**

Do you have a family history of any of the following?

**Y N** High Blood Pressure
**Y N** Heart Attack
**Y N** Emphysema
**Y N** Seizures or Convulsions
**Y N** Kidney Disease
**Y N** Asthma
**Y N** Diabetes
**Y N** Other:_____

**Y N** Ulcer or Stomach Problems
**Y N** Stroke
**Y N** Cancer (type:_____)
**Y N** Arthritis-Rheumatism
**Y N** Mental Illness
**Y N** Thyroid Disease
**Y N** Circulation Problems

Patient's Signature: _____ Date:_____

**REVIEW OF SYSTEMS**

Have you had or do you currently have any of the following symptoms?

| | | | | | |
|---|---|---|---|---|---|
| Headaches (Frequency _____) | **Y** | **N** | Loss of Balance | **Y** | **N** |
| Neck Pain | **Y** | **N** | Fainting | **Y** | **N** |
| Stiff Neck | **Y** | **N** | Loss of Smell | **Y** | **N** |
| Sleeping Problems | **Y** | **N** | Loss of Taste | **Y** | **N** |
| Back Pain | **Y** | **N** | Unusual Bowel Patterns | **Y** | **N** |
| Nervousness | **Y** | **N** | Feet Cold | **Y** | **N** |
| Tension | **Y** | **N** | Hands Cold | **Y** | **N** |
| Irritability | **Y** | **N** | Arthritis | **Y** | **N** |
| Chest Pains/Tightness | **Y** | **N** | Muscle Spasms | **Y** | **N** |
| Dizziness | **Y** | **N** | Frequent Colds | **Y** | **N** |
| Shoulder/Neck/Arm Pain | **Y** | **N** | Frequent Fever | **Y** | **N** |
| Numbness in Fingers | **Y** | **N** | Sinus Problems | **Y** | **N** |
| Numbness in Toes | **Y** | **N** | Diabetes | **Y** | **N** |
| High Blood Pressure | **Y** | **N** | Indigestion Problems | **Y** | **N** |
| Difficulty Urinating | **Y** | **N** | Joint Pain/Swelling | **Y** | **N** |
| Weakness in Extremities | **Y** | **N** | Menstrual Difficulties | **Y** | **N** |
| Breathing Problems | **Y** | **N** | Weight Loss/Gain | **Y** | **N** |
| Fatigue | **Y** | **N** | Depression | **Y** | **N** |
| Lights Bother Eyes | **Y** | **N** | Loss of Memory | **Y** | **N** |
| Ears Ring | **Y** | **N** | Buzzing in Ears | **Y** | **N** |

*For Women Only*
Are you pregnant? □ yes □ no
If yes, how many weeks? _____

Patient's Signature: _____ Date:_____

Is this a new issue? □ YES □ NO

*If yes, please answer the following:*

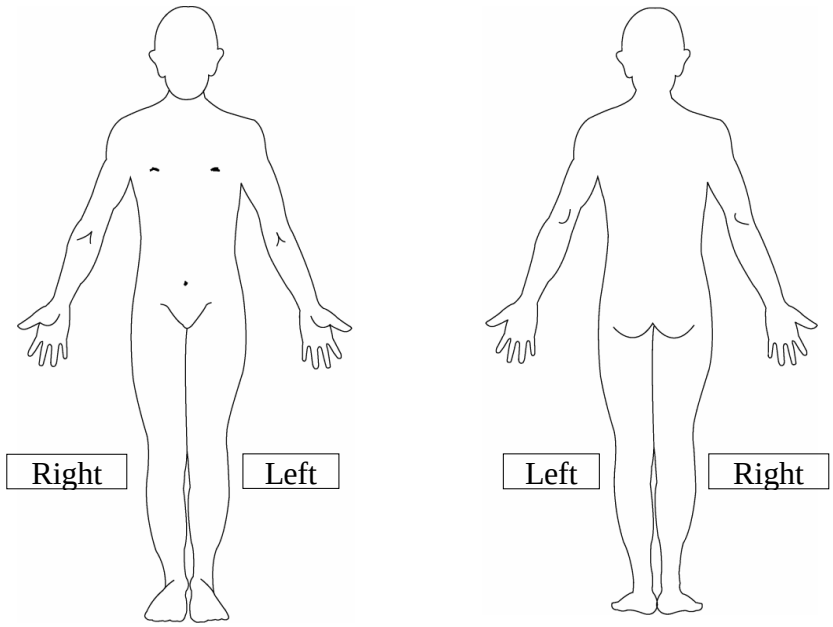
When did you first notice this problem/pain? _____

How do you believe this problem/pain began? _____

Have you taken medication(s) for this problem? If so, what medication(s)? _____

**Mark the areas on the drawings below where you feel the described sensations. Include all affected areas.**

**Pain Chart**




On the scale from zero to 10, please mark your current level of pain or discomfort.

**0**_____ **10**

**no pain** **worst pain**

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| | | | |
|---|---|---|---|
| This complaint came on: | □ Gradually | □ Immediately | |
| It is getting: | □ Better | □ Staying the same | □ Worse |
| The intensity of this complaint is: | □ Minimal<br>□ Slight | □ Moderate | □ Severe |
| The frequency of this complaint is: | □ Occasional | □ Frequent | □ Constant |
| The pain is: | □ Dull<br>□ Shooting<br>□ Burning | □ Sharp<br>□ Spasm<br>□ Tingling | □ Aching<br>□ Throbbing |

Patient's Signature: _____ Date:_____

**Actions affecting this complaint:**

| | | | |
|---|---|---|---|
| Morning | □ Brings on | □ Aggravates | □ Relieves |
| Evening | □ Brings on | □ Aggravates | □ Relieves |
| Cold | □ Brings on | □ Aggravates | □ Relieves |
| Heat | □ Brings on | □ Aggravates | □ Relieves |
| Standing | □ Brings on | □ Aggravates | □ Relieves |
| Sitting | □ Brings on | □ Aggravates | □ Relieves |
| Lying down | □ Brings on | □ Aggravates | □ Relieves |
| Bending forward | □ Brings on | □ Aggravates | □ Relieves |
| Bending back | □ Brings on | □ Aggravates | □ Relieves |
| Twisting left | □ Brings on | □ Aggravates | □ Relieves |
| Twisting right | □ Brings on | □ Aggravates | □ Relieves |
| Lifting | □ Brings on | □ Aggravates | □ Relieves |

Any additional details/information:

Patient's Signature: _____ Date: _____

## Patient Informed Consent for Treatment

I, _____ do hereby give my consent to the performance of Chiropractic treatment. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues and physiotherapies and exercises may also be used. I consent to the performance of examinations and testing for proper diagnosis and treatment.

I have disclosed all of my past medical history to my doctor so that an appropriate treatment plan can be developed. I am aware of the risks associated with my treatment, the most common of which is soreness in the treated area, and fully and freely accept those risks. I will report any soreness or discomfort that I feel, from the treatment or otherwise, promptly to my doctor.

Patient Signature: _____ Date: _____

*If under 18,*
Parent or guardian signature: _____ Date: _____