Chiropractic Case History/Patient Information

Pt #____

Name ______________________ Age ______ Cell Phone ______________ E-Mail ______________

Marital Status: S☐ M☐ D☐ W☐ # of Children_____ Referred by______________________

What do you think is wrong? ____

Have you ever been treated by a Chiropractor? Yes ☐ No ☐ Results ______________________

What does your condition prevent you from doing or enjoying?____________________________

____

Did your problem begin suddenly ☐ or gradually ☐ Is this is a recurrence Yes☐ No ☐ If yes, when was the first time you noticed this problem?______ Has it become worse recently? Yes ☐ No ☐ Same ☐ Better☐ Gradually Worse☐

How long does it last? All Day ☐ Few Hours ☐ Minutes ☐ Night Only ☐ Constant ☐

Describe the pain: Sharp ☐ Dull☐ Numbness☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing☐

Other____

Describe the intensity- Mild ☐ Moderate☐ Severe ☐ Does anything make it better? Yes ☐ No ☐ If yes, what helps ____

If no, what have you tried to do that has not helped? ______________________________

____

What makes the problem worse? Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐

Other ____

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 you would like evaluated? Yes ☐ No ☐ If yes, describe______________

____

Do you take nutritional supplements?______Describe____________________________________

____

Check if you wear: Arch supports _____ Heel lifts_____Special shoes_____Mouthpiece_____ Joint braces/supports______

Do you exercise? Yes☐ No☐ If yes, describe______________________________________

____

How many glasses of WATER do you drink/day?______

Do you have allergies?____ Food☐ Drug☐ What reactions have you had?____________________

24 hour notice is necessary for cancellations and you may be responsible for payment of a missed appointment.

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 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.

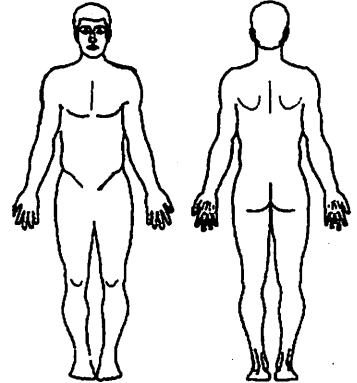
Patient's Signature ____ Date__________

Guardian's Signature Authorizing Care__________________________ Date__________

INITIAL HEALTH STATUS

Patient Name: ______________________ Birthdate: ______________ Sex: M / F
Address: ______________________ City: ______________ State: ______ Zip: ________
Telephone: ______________ Social Security #: ______________ Driver Lic. #: ______________
Occupation: ______________ Employer: ______________ Work Phone: ______________
Address: ______________________ City: ______________ State: ______ Zip: ________
Subscriber Name: ______________________ Health Plan: ______________________
Subscriber ID #: ______________ Group #: ______________ Spouse Name: ______________
Spouse Employer: ______________ City: ______________ State: ______ Zip: ________
Primary Care Physician Name: ______________________ PCP Phone: ______________

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

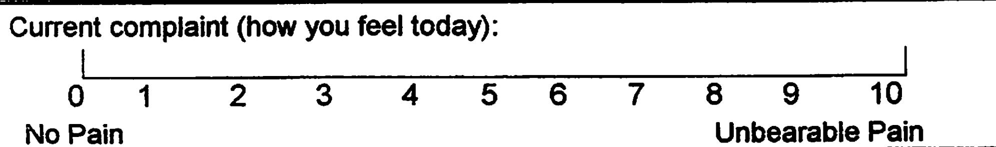
☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain

☐ Other ______________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: ______________________

How Problem Began: ______________________



Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe any current activity limitations) ______________

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** ______________

WHAT AREAS WERE TAKEN? ______________________

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition	No	Yes	Condition
☐	☐	History of Recent Infection	☐	☐	Prostate Problems
☐	☐	Recent Fever	☐	☐	Frequent Urination
☐	☐	HIV/AIDS	☐	☐	Currently Pregnant, # weeks ________
☐	☐	Diabetes	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Corticosteroid Use	☐	☐	Epilepsy/Seizures
☐	☐	Birth Control Pills	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	Low/Mid Back Pain
☐	☐	Stroke (date) ____________	☐	☐	Neck Pain
☐	☐	Dizziness/Fainting	☐	☐	Arthritis
☐	☐	Numbness in Groin/Buttocks	☐	☐	History of Alcohol Use
☐	☐	Urinary Retention	☐	☐	History of Tobacco Use
☐	☐	Aortic Aneurysm	☐	☐	Nocturnal Pain (pain at night)
☐	☐	Cancer/Tumor	☐	☐	Surgeries ____________
☐	☐	Osteoporosis			
☐	☐	Recent Trauma	☐	☐	Medications: ____________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ______________________ **Date:** ______________