

# Chiropractic Case History/Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How many children? \_\_\_\_\_ Names & Ages of Children: \_\_\_\_\_

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

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

Family Medical Doctor: \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_

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

Major Medical     Worker's Compensation     Medicaid     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. [The following person\(s\) have my permission to receive my personal health information:](#)**

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Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Doctor \_\_\_\_\_

## HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: \_\_\_\_\_

Purpose of 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 yes, when and describe: \_\_\_\_\_

Days lost from work: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

Do you have a history of stroke or hypertension? \_\_\_\_\_

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

Have you been treated for any health condition by a physician in the last year?     Yes     No

If yes, describe: \_\_\_\_\_

Have you received previous chiropractic care or physical therapy? Y / N

What medications or drugs are you taking? \_\_\_\_\_

Do you have any allergies to any medications?  Yes     No

If yes, describe: \_\_\_\_\_

Do you have any allergies of any kind?  Yes     No

If yes, describe: \_\_\_\_\_

Do you have any Congenital Condition (From Birth) ? \_\_\_ Yes \_\_\_ No

If YES, Describe \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously
Headaches _____ Frequency _____		Loss of Balance _____
Neck Pain _____		Fainting _____
Stiff Neck _____		Loss of Smell _____
Sleeping Problems _____		Loss of Taste _____
Back Pain _____		Unusual Bowel Patterns _____
Nervousness _____		Feet Cold _____
Tension _____		Hands Cold _____
Irritability _____		Arthritis _____
Chest Pains/Tightness _____		Muscle Spasms _____
Dizziness _____		Frequent Colds _____
Shoulder/Arm Pain _____		Fever _____
Numbness in Fingers _____		Sinus Problems _____
Numbness in Toes _____		Diabetes _____
High Blood Pressure _____		Indigestion Problems _____
Difficulty Urinating _____		Joint Pain/Swelling _____
Weakness in Extremities _____		Menstrual Difficulties _____
Breathing Problems _____		Weight Loss/Gain _____
Fatigue _____		Depression _____
Lights Bother Eyes _____		Loss of Memory _____
Ears Ring _____		Buzzing in Ears _____
Broken Bones/Fractures _____		Circulation Problems _____
Rheumatoid Arthritis _____		Seizures/Epilepsy _____
Excessive Bleeding _____		Low Blood Pressure _____
Osteoarthritis _____		Osteoporosis _____
Pacemaker _____		Heart Disease _____
Stroke _____		Cancer _____
Ruptures _____		Coughing Blood _____
Eating Disorder _____		Alcoholism _____
Drug Addiction _____		HIV Positive _____
Gall Bladder Problems _____		
Ulcers _____		

### SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:  
OFTEN= "O"    SOMETIMES= "S"    NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify) _____
_____ Tobacco Use	
_____ Caffeine	
_____ High Stress Activity	

## FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]	Age [ ]
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
HighBlood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

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I certify the information provided is accurate to the best of my knowledge:

Name of Patient \_\_\_\_\_

Signature of Patient/Legal Guardian \_\_\_\_\_

# Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, acupuncture and/or other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_