



Case History

Date: _____ **Patient #** _____

Name: _____ **Social Security #** _____ **Home Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-mail address: _____ **Fax #** _____ **Cell Phone:** _____

Age: _____ **Birth Date:** _____ **Race:** _____ **Marital:** M S W D

Occupation: _____ **Employer:** _____

Employer's Address: _____ **Office Phone:** _____

Spouse: _____ **Occupation:** _____ **Employer:** _____

Please check any and all insurance coverage that may be applicable in this case:
 Major Medical__ Worker's Compensation__ Medicaid__ Medicare__ Automobile__
 Medical Savings Account & Flex Plans__

Name of Primary Insurance Company: _____

Subscriber/Policy # _____ **Group ID:** _____

Name of Secondary Insurance Company (if any): _____

Subscriber/Policy # _____ **Group ID:** _____

Emergency Contact: _____ **Address:** _____ **Phone:** _____

Family Medical Doctor: _____ **Phone:** _____ **Date of Last Exam:** _____

How were you referred to our office? (If internet search, be specific) _____

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

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

What makes it better? _____ **Worse?** _____

Please describe your condition in detail and rate your pain (if applicable) on a scale of 1 to 10 (with 10 being unbearable): _____

Have you sought treatment elsewhere for this condition? _____

Is this due to: Auto__ Work__ Other _____ **Days lost from work** _____

If this is due to an accident, are there legal measures involved? _____

Have you ever had the same or a similar condition? Yes__No__ **If yes, when and describe:** _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Alcohol/Drug Addiction
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Stroke/TIAs	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other _____

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

What medications or drugs are you taking? (Please include any herbal supplements): _____

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: _____

Please list any other health problems you have or anything else you would like for us to know: _____

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? _____

What percentage of time during the day do you spend:

lifting___ sitting___ bending___ working at a computer _____

FAMILY HISTORY:

Father: living___ deceased___ Current age if still living:___ Cause of death and age at death if deceased: _____

Mother: living___ deceased___ Current age if still living:___ Cause of death and age at death if deceased: _____

FAMILY DISEASES

Tuberculosis _____

Cancer _____

Mental Illness _____

Diabetes _____

Asthma _____

Heart Disease _____

Stroke _____

Kidney Disease _____

Lung Disease _____

Arthritis _____

Liver Disease _____

Other _____

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: _____

REASON FOR CARE

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. 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? _____
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ Few Hours ___ Minutes _____
5. 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 _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
7. 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? _____

8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain ___
11. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

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

Doctor's Signature _____ Date _____