

# Chiropractic Case History/Patient Information

Date: \_\_\_\_\_ Patient # \_\_\_\_\_ Doctor: \_\_\_\_\_

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

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

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

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ M/F: \_\_\_\_\_ Marital: M S W D

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

Employer's Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

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

How many children? \_\_\_\_\_ Names and 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? \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS:

Chief complaint for this appointment: Please mark ALL areas of Pain →

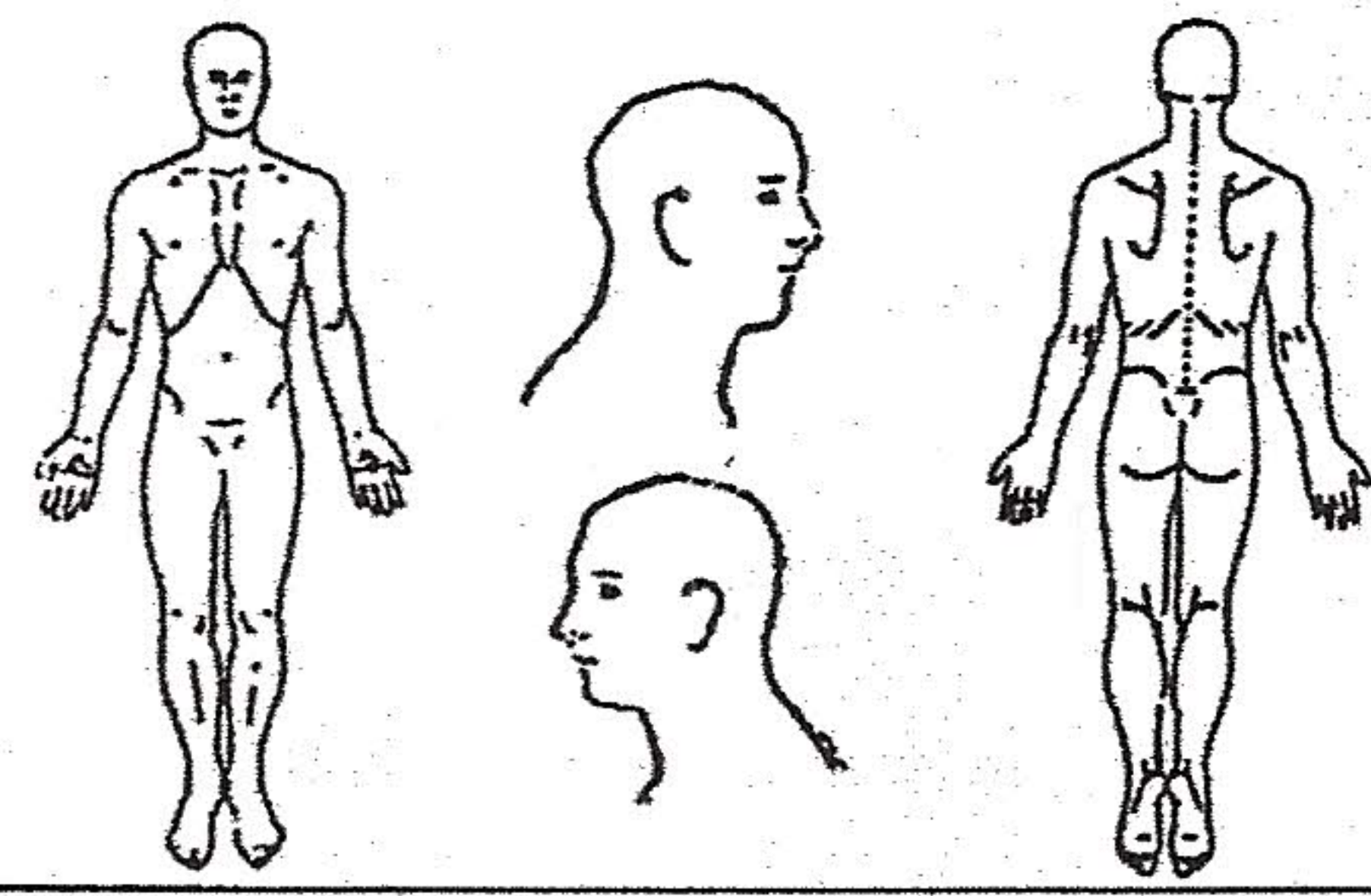
Date symptoms appeared or accident happened: \_\_\_\_\_

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: \_\_\_\_\_



Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

## 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"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems      | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Alcoholism      |
| <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> Pace Maker     | <input type="checkbox"/> Drug Addiction  |
| <input type="checkbox"/> Seizures/Convulsions      | <input type="checkbox"/> Strokes        | <input type="checkbox"/> HIV Positive    |
| <input type="checkbox"/> A Congenital Disease      | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Gall Bladder    |
| <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Ruptures       | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> High/Low Blood Pressure   | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers          |

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): \_\_\_\_\_

Women, is there ANY chance you are pregnant?  Yes  No Date of last menstrual cycle \_\_\_\_\_

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? \_\_\_\_\_

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, no matter how insignificant they may be:

\_\_\_\_\_  
\_\_\_\_\_

**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 take vitamin supplements? \_\_\_ If so, please list: \_\_\_\_\_

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 (at home or at your job away from home) do you spend:

lifting \_\_\_ sitting \_\_\_ bending \_\_\_ working at a computer \_\_\_\_\_

**FAMILY HISTORY :**

Parents:

Father: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_ (check one)

Mother: living \_\_\_ deceased \_\_\_ Current age if still living: \_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_ (check one)

Check if applicable to you: \_\_\_\_\_ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list:

\_\_\_\_\_

**FAMILY DISEASES** (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis \_\_\_\_\_

Cancer \_\_\_\_\_

Mental Illness \_\_\_\_\_

Diabetes \_\_\_\_\_

Asthma \_\_\_\_\_

Heart Disease \_\_\_\_\_

Stroke \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Lung Disease \_\_\_\_\_

Arthritis \_\_\_\_\_

Liver Disease \_\_\_\_\_

Other \_\_\_\_\_

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.

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

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