Patient Information/ Case History

Name _____ Social Security # ☐☐☐–☐☐–☐☐☐☐

Address_____City _____State_____ Zip_____

(Please write your email address to receive our Back to Health newsletter and appointment confirmations)

Home Phone _____Cell _____E-mail address: _____

Age _____ Birth Date _____ Race _____ Marital: M S W D How many children?_____

Occupation _____ Employer _____

Employer's Address _____ Office Phone_____

Spouse _____ Occupation _____Employer _____

Name of Nearest Relative_____Address_____Phone _____

Who referred you to our office? _____

Would you like a Report sent your Family Medical Doctor: ( ) Yes ( ) No

Family Doctor Name: _____ Phone Number _____

Family Doctor Address: _____

Have you ever had the same or a similar condition? ( ) Yes ( ) No If yes, when and describe:_____

_____

Date of last physical examination _____ What surgeries have you had? (Include dates)_____

_____

Serious illnesses or accidents in the past: (include dates) _____

_____

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? _____

Health Insurance: ( ) Yes ( ) No Insurance Company _____

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. I understand that interest is charged on overdue accounts at the annual rate of 16%, any check written that is not valid will be subject to a $25 fee per check. If this account is transferred to collections, all attorneys' fees and cost accrued will be my responsibility. I understand and consent to photography, video recording and its release for promotional purposes. I understand that, as with any health care procedures, there are certain complications which may arise during treatment. I will discuss any concerns of complications with the doctor prior to treatment. 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 *(required)* _____ Date_____

Guardian's Signature Authorizing Care _____ Date_____

1. What is your major symptom? _____

2. 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? _____

3. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____

4. 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 _____

5. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____

6. 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? _____
   _____

7. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____

8. Have you had any broken bones? Yes ____ No ____. If yes, please list and give dates _____
   _____

9. List any major accidents you have had other than those that might be mentioned above: _____
   _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ____ No ____. If yes, please explain _____
    _____

11. Please place circle on the number below to indicate your level of problem.

NO SYMPTOMS									EXTREME SYMPTOMS
1	2	3	4	5	6	7	8	9	10

---------- Doctor Notes Below ----------

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Past Trauma: **Surgeries:** **Hospitalizations/ Illness:**
Family History: Diabetes, Heart Disease, Cancer, Arthritis, Similar Conditions

Patient Goals: