Chiropractic Case History/Patient Information

Name:_____ Home Phone: _____ Cell Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____

Age:_____ Birth Date:_____ Marital: Married Single Widowed Divorced

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Emergency contact: _____ Phone: _____

How many children?_____Names and Ages of Children:_____

_____

Whom may we thank for referring you?_____

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 Spine & Sports Chiropractic 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:

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PATIENT NAME _____ DATE _____

HISTORY OF PRESENT AND PAST ILLNESS:

Describe your major complaint(s):

_____

_____

Date symptoms appeared: _____ Describe how they began:_____

_____

Is this due to: Auto___ Work____ Other_____

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

How often do you experience these symptoms:

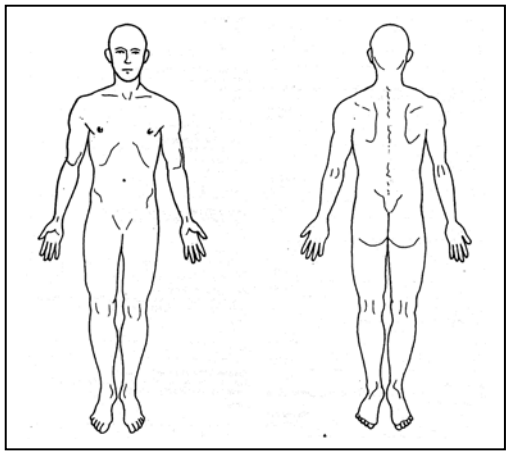
[ ] Constantly (76%– 100% of the day)

[ ] Frequently (51% – 75% of the day)

[ ] Occassionaly (26% - 50% of the day)

[ ] Intermittently (0% - 25% of the day)

MARK BELOW WHERE YOU HAVE SYMPTOMS



How would your describe the symptoms?

[ ] Sharp [ ] Shooting [ ] Stabbing [ ] Weakness [ ] Dull [ ] Stiffness

[ ] Numb [ ] Tingling [ ] Cramps [ ] Achy [ ]Burning [ ] Throbbing

How are your symptoms changing?

[ ] Getting better [ ] Getting worse [ ] No change

How would you rate your symptoms at their:

	NONE										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform you daily living activities and at work?

0	1	2	3	4	5	6	7	8	9	10
No complaints	Mild, forgotten with activity		Moderate, interferes with activity		Limits, prevents full activity		Intense, preoccupied with seeking relief			Severe, no activity possible

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you seen any other health care professionals for this condition? [ ] Yes [ ] No If yes list providers:

Name Address Date

_____

_____

Have you had any other tests done for your symptoms? [ ] Yes [ ] No If yes, please check test and give date.

[ ] X-rays _____ [ ] MRI _____ [ ] CT Scan _____ [ ] Lab _____ [ ] Other _____

Have you ever received chiropractic care before? [ ] Yes [ ] No If yes, please list:

Name Address Date

_____

PATIENT NAME _____ DATE _____

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
[ ]	[ ]	Headaches	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Diabetes
[ ]	[ ]	Neck Pain	[ ]	[ ]	Heart Attack	[ ]	[ ]	Excessive Thirst
[ ]	[ ]	Upper Back Pain	[ ]	[ ]	Chest Pains	[ ]	[ ]	Frequent Urination
[ ]	[ ]	Mid Back Pain	[ ]	[ ]	Stroke	[ ]	[ ]	Chronic Sinusitis
[ ]	[ ]	Low Back Pain	[ ]	[ ]	Angina	[ ]	[ ]	Smoking/Use Tobacco Products
[ ]	[ ]	Shoulder Pain	[ ]	[ ]	Kidney Stones	[ ]	[ ]	Drug/Alcohol Dependence
[ ]	[ ]	Elbow/Upper Arm Pain	[ ]	[ ]	Kidney Disorders	[ ]	[ ]	Allergies
[ ]	[ ]	Wrist Pain	[ ]	[ ]	Bladder Infection	[ ]	[ ]	Depression
[ ]	[ ]	Hand Pain	[ ]	[ ]	Painful Urination	[ ]	[ ]	Systemic Lupus
[ ]	[ ]	Hip/Upper Leg Pain	[ ]	[ ]	Loss of Bladder Control	[ ]	[ ]	Epilepsy
[ ]	[ ]	Knee/Lower Leg Pain	[ ]	[ ]	Prostate Problems	[ ]	[ ]	Dermatitis/Eczema/Rash
[ ]	[ ]	Ankle/Foot Pain	[ ]	[ ]	Abnormal Weight Loss/Gain	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Jaw Pain	[ ]	[ ]	Loss of Appetite			
[ ]	[ ]	Joint Swelling/Stiffness	[ ]	[ ]	Abdominal Pain	**Females Only**		
[ ]	[ ]	Arthritis	[ ]	[ ]	Ulcer	[ ]	[ ]	Birth Control Pills
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	Hepatitis	[ ]	[ ]	Hormonal Replacement
[ ]	[ ]	General Fatigue	[ ]	[ ]	Liver/Gall Bladder Disorder	[ ]	[ ]	Pregnancy
[ ]	[ ]	Muscular Incoordination	[ ]	[ ]	Cancer			
[ ]	[ ]	Visual Disturbances	[ ]	[ ]	Tumor			
[ ]	[ ]	Dizziness	[ ]	[ ]	Asthma			

Other Health Problems / Issues

[ ] [ ] _____
[ ] [ ] _____
[ ] [ ] _____

List all Prescription and over-the-counter medications, and nutritional / herbal supplements you are taking:

_____

_____

List all the surgical procedures you have had and the times you have been hospitalized:

_____

_____

Doctor's Additional Comments:

_____

_____

SOCIAL / WORK HISTORY

Excersie	Work Activity	Habits
[ ] None	[ ] Sitting	[ ] Smoking Packs / day _____
[ ] Moderate	[ ] Standing	[ ] Drinking Drinks / week _____
[ ] Daily	[ ] Light Labor	[ ] Caffine Cups / day _____
[ ] Heavy	[ ] Heavy Labor	[} Stress Reason _____

PATIENT NAME _____ DATE _____

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 Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN 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:

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

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____