

Chiropractic Case History

Date _____

Name _____ SS# _____ Home Phone _____

Address _____ City _____ Zip _____

E-Mail Address _____ Cell Phone _____

Race _____ Marital Status: M S W D Number of Children _____

Age ___ Birth Date _____ How were you referred to us ? _____

Work Information:

Occupation _____ Employer _____

Employer's Address _____ Work Phone _____

Emergency Information

Emergency Contact _____ Relation _____

Home Phone _____ Cell Phone _____

Health History:

What brings you into our office today? (Chief Complaint) _____

Date your current condition began: _____

Is your condition due to: Work Auto Accident Trauma Other

Please Describe Cause of Complaint _____

Have you ever experienced these symptoms before? Y/N If so, when _____

Have you been treated by any other healthcare provider within the past year? Y/N

If so, for what condition(s)? _____

Do you currently have any significant health related issues or diseases? Y/N

Please list: _____

What surgeries have you had? (list dates) _____

List any broken bones or dislocations: _____

What medication(s) are you currently taking? _____

What nutritional supplement(s) are you currently taking? _____

How would you describe your overall health? Excellent Good Fair Poor

Women only: *To the best of your knowledge, are you currently pregnant? Y/N*

Past Chiropractic History:

Have you ever been to a chiropractor before? Y/N

If so, for what condition(s) _____

When was your last adjustment? _____ Dr.'s Name _____

What is your medical doctor's name? _____

Insurance Information:

Primary Insurance _____

Secondary Insurance _____

Do you have a Health Savings Account (HAS), Health Reimbursement Account (HRA), or Flexible Spending Account (ex. – Flexben)? Y/N

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Your Current Condition:

Name _____

1. Please List Your Current Complaint(s):

- A. _____ (Chief Complaint)
- B. _____
- C. _____
- D. _____

2. Please rate your discomfort level:

0 1 2 3 4 5 6 7 8 9 10
Pain Free _____ Excruciating Pain

3. Is your condition: Worsening Staying the same Getting better

4. How frequent is it?

Constant Frequent Intermittent Occasional

5. Can you think of any other conditions, which may be related to your complaints? Y/N

Please describe _____

6. Describe the pain: Sharp Dull Numb Tingling Achy
 Burning Stabbing Other _____

7. What makes your condition better _____

8. What makes your condition worse? _____

9. Have you had any major accidents in the past, which may be currently affecting your condition? _____

10. What is the primary goal of your care with our office? (Please check one answer)

- Temporary Pain Management
- Correction And Stabilization Of Your Condition
- Improve Overall Health
- Decrease Dependency On Medication
- Preventative Wellness Care

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 payers 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 the interest charge on overdue accounts is at the annual rate of 16%.

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 healthcare information will be used by this office and your rights in regards to your records. If you would like a more detailed account of our policies and procedures concerning the privacy of your records, 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 records, please inform our office.

Patient/Guardian Signature _____ **Date** _____

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