Chiropractic Case History/Patient Information

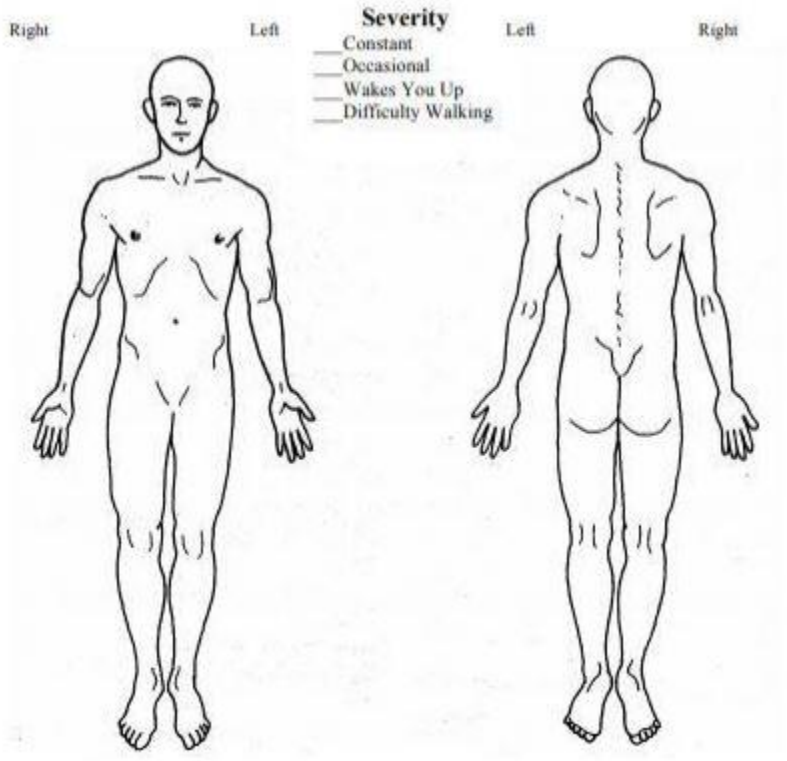
Date___ /___/___
Name_____ Social Security #_____Phone_____
Address_____ City_____ State _____ Zip_____
Email Address_____ Cell Phone _____
Age_____ Date of Birth___ /___/___ Sex _____ Marital Status: M S D W No. of Children_____
Occupation_____ Shift_____ Description_____
Employer_____ Employer Address_____
Work Phone_____
Spouse_____ Occupation_____
Employer_____ Employer Address_____
Emergency Contact_____ Address_____ Phone_____
Family Medical Doctor_____ OB/GYN_____
Date symptoms appeared or accident happened ___ /___/___
Have you ever had the same or similar condition? YES □ NO □ If yes, when and describe_____
_____ If days of work lost, how many?_____
Date of last physical exam___ /___/___ What surgeries have you had? (Include dates)_____
_____
Serious Illnesses (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 currently taking?_____
Please check any and all insurance coverage that may be applicable in this case:
□ Major Medical □ Medicare □ Medicaid □ Other
□ Workman's Comp – Have you made a report? □ YES □ NO
□ Auto Accident – Have you made a report? □ YES □ NO
Name of Primary Insurance Company_____
Name of Secondary Insurance Company (if any)_____
What is your major symptom? □ Headache □ Neck □ Arm/Hand □ Hip □ Upper Back □ Lower Back □ Leg/Feet
*See page 2 – Indicate location and severity of pain or discomfort
If this is a recurrence, when was the first time you noticed the problem? ___ /___/___
How did it originally occur? _____
Has there been a recent change in your condition? □ YES □ NO
If yes, was the change □ Gradual Worsening □ Sudden Worsening □ Better
If there has been a change, when and how did it occur? _____
Is there anything you can do to relieve the problem? _____
If no, what have you tried that has not helped? _____
What makes the problem worse? □ Standing □ Sitting □ Lying □ Bending □ Lifting □ Twisting
□ Other_____
Have you ever had any broken bones? □ YES □ NO If yes, please list and give dates_____
_____
List any major accidents and their dates you have had other than those that might be mentioned above _____
_____
To your knowledge, have you had any diseases, major illnesses or injuries not indicated on this form either in the past or recently? □ YES □ NO If yes, please list and give dates_____
Have you had any of the following: □ Epilepsy □ Heart Disease □ Gout □ Stroke □ Cancer □ Colon Trouble □ Other_____

WOMEN ONLY: Are you pregnant? □ YES □ NO □ NOT SURE

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Put a check by the type(s) of pain you feel. Then rate your pain on the scale, at its *worst*.

Ache ___ Numbness ___ Pins & Needles ___ Burning ___ Stabbing ___ Throbbing ___

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain



Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to the allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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 doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I hereby authorize you to release or obtain any information including x-rays, diagnoses and records of examination or treatment rendered.

Patient Signature_____ Date _____

Witness Signature_____ Date_____

Doctor Signature_____ Date_____