

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: _____ Race: _____ 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 (first and last name): _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

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: _____

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"/> Prosthesis
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Coughing Blood
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Fainting	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Any Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder	
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Ruptures	<input type="checkbox"/> Depression	

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents, hospitalizations or surgeries? Women, please include information about childbirth (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? _____

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

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

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 _____

High Blood Pressure _____

Other _____

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 given 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: _____

Date: _____

Guardian's Signature Authorizing Care: _____

Date: _____