

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