Chiropractic Case History/Patient Information

Name:____________________________ Social Security #___________________Home Phone: ________________

Address:______________________________________City:____________________ State:______ Zip:___________

E-mail address:____ Cell Phone:_________________________

Age:_______ Birth Date:___________ Race:______ Marital Status: [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:____ Relationship: _________________

Address:____Phone:_____________________

How were you referred to our office?____

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 circle any and all insurance coverage that may be applicable in this case**:**

Major Medical Worker's Compensation Medicaid Medicare Auto Accident (PI)
Medical Savings Account & Flex Plans Other_____________________________________

Name of Primary Insurance Company:____
Name of Secondary Insurance Company (if any):____
(A currant copy of your drivers license and insurance card must be a part of this complete medical file)

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 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 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:

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? π Yes π No If yes, when and describe:_______________

____

Days lost from work:__________________ Date of last physical examination:__________________________

Do you have a history of stroke or hypertension?____

Have you had any major illnesses, injuries, falls, auto accidents 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? π Yes π No

If yes, describe:____

What medications or drugs are you taking?____

____

Do you have any allergies to any medications? π Yes π No

If yes, describe:____

Do you have any allergies of any kind? π Yes π No

If yes, describe:____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _________________________________

Women: Are you pregnant?____________________

Treatment: What type of treatment are you looking for?

___ I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.

___ I am looking to resolve my symptoms and then go on to “correct the cause” of my problem.

___ I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

___________ Vigorous Exercise

___________ Moderate Exercise

___________ Alcohol Use

___________ Drug Use

___________ Tobacco Use

___________ Caffeine

___________ High Stress Activity

__________ Family Pressures

__________ Financial Pressures

__________ Other Mental Stresses

__________ Other (specify)______

____

____

Do you take Vitamin’s? Y N

PATIENT NAME ____ DATE _____________________

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches______ Frequency	_________	Loss of Balance	___________
Neck Pain	_________	Fainting	___________
Stiff Neck	_________	Loss of Smell	___________
Sleeping Problems	_________	Loss of Taste	___________
Back Pain	_________	Unusual Bowel Patterns	___________
Nervousness	_________	Feet Cold	___________
Tension	_________	Hands Cold	___________
Irritability	_________	Arthritis	___________
Chest Pains/Tightness	_________	Muscle Spasms	___________
Dizziness	_________	Frequent Colds	___________
Shoulder/Neck/Arm Pain	_________	Fever	___________
Numbness in Fingers	_________	Sinus Problems	___________
Numbness in Toes	_________	Diabetes	___________
High Blood Pressure	_________	Indigestion Problems	___________
Difficulty Urinating	_________	Joint Pain/Swelling	___________
Weakness in Extremities	_________	Menstrual Difficulties	___________
Breathing Problems	_________	Weight Loss/Gain	___________
Fatigue	_________	Depression	___________
Lights Bother Eyes	_________	Loss of Memory	___________
Ears Ring	_________	Buzzing in Ears	___________
Broken Bones/Fractures	_________	Circulation Problems	___________
Rheumatoid Arthritis	_________	Seizures/Epilepsy	___________
Excessive Bleeding	_________	Low Blood Pressure	___________
Osteoarthritis	_________	Osteoporosis	___________
Pacemaker	_________	Heart Disease	___________
Stroke	_________	Cancer	___________
Ruptures	_________	Coughing Blood	___________
Eating Disorder	_________	Alcoholism	___________
Drug Addiction	_________	HIV Positive	___________
Gall Bladder Problems	_________	Depression	___________
Ulcers	_________		

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

______________________	______________________	__________
Printed Name	**Signature**	**Date**

WITNESS:

______________________	______________________	__________
Printed Name	**Signature**	**Date**

TREATMENT AUTHORIZATION

I, ____, certify that the complaints listed below are true as related by me. I wish to be treated for these complaints and any additional complaints or problems, which may arise during the course of my treatment in this office today.

COMPLAINTS/	ACTIVITIES IMPAIRED DUE TO CONDITION
1.	/
2.	/
3.	/
4.	/
5.	/
6.	/

VISUAL PAIN INTENSITY SCALE

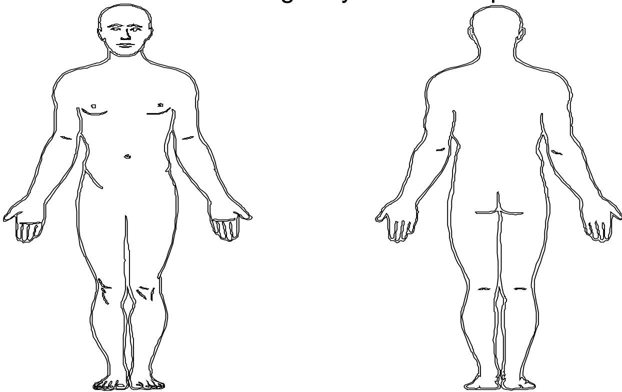
What is your pain ***RIGHT NOW***?
No pain 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

What is your ***TYPICAL or AVERAGE*** pain?
No pain 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

What is your pain level ***AT ITS BEST*** (How close to "0" does your pain get at its best)
No pain 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?
No pain 0 1 2 3 4 5 6 7 8 9 10 *worst possible pain*

Shade or mark on the figure your area of pain



Date:____________________

Patient's Signature: ____
Legal Guardian Signature:____