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Chiropractic Case History/Patient Information

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_ Marital: M S W D

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Nearest Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical Doctor Name and Address/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?\_\_\_\_\_\_\_\_\_\_\_

The following person(s) have my permission to receive my personal health information:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian's Signature Authorizing Care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*ATTENTION\*\*\*\***

**Please note that due to the fact that we are a non-insurance practice, we do not work in any way with any type of insurance. This includes regular medical insurance, workers comp or personal injury. We will not submit any notes or claims. The only thing we will be able to give you is a print out of your billing information which includes the date or service, the service we gave you, the price and the amount you paid. This allows us to offer a discounted price to you.**

**Our office also asks that you respect our no show policy. The first time that you do not call to cancel your appointment prior to your appointment time and do not show up, you will not be assessed a fee, but ANY NO SHOW AFTER THAT WITHOUT NOTICE WILL BE ASSESSED A $19 FEE.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF PRESENT AND PAST ILLNESS:**

Chief Complaint: Purpose of this appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date symptoms appeared:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this due to: Auto\_\_\_ Work\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had the same or a similar condition? Yes No If yes, when and describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? Yes No

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications are you taking?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any Congenital Condition? \_\_\_Yes \_\_\_ No If YES, Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you pregnant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check off if you have or have had any of the following symptoms/conditions:

 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 \_\_\_\_\_\_\_\_ Ulcers \_\_\_\_\_\_\_\_­­­­­­

**Patient Health Information Consent Form**

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to any company provided to us by the patient for the purpose of payment or requested information by other doctors, lawyers, etc. Be assured that this office will limit the release of all PHI to the minimum needed for what the company requires for payment or information requested.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date