

Patient Information

Date

Name Social Security # Home Phone
Address City State Zip
E-mail address: Fax # Cell Phone
Age Birth Date Race Marital: M S W D How many children?
Occupation Employer
Employer's Address Office Phone
Spouse Occupation Employer
Name of Nearest Relative Address Phone
How were you referred to our office?
Family Medical Doctor
Purpose of this appointment
Date symptoms appeared or accident happened
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 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 nutrients are you currently taking?

What medications or drugs are you taking?

Please check any and all insurance coverage that may be applicable in this case.

Major Medical	Worker's Compensation	Medicaid
Medicare	Auto Accident	Other

Name of Primary Insurance Company

Name of Secondary Insurance Company (if any)

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature

Date

Guardian's Signature Authorizing Care

Date

Chiropractic Case History/Patient Information

1. What is your major symptom?

2. If this is a recurrence, when was the first time you noticed this problem?

_____ How did it originally occur?

_____ Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse

_____ If yes, when and how?

3. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only

_____ How long does it last? All Day _____ Few Hours _____ Minutes

4. Are there any other conditions or symptoms that may be related to your major symptom?

Yes _____ No _____. If yes, describe

_____ Are there other unrelated health problems? Yes _____ No _____. If yes, describe

5. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching

_____ Burning _____ Stabbing _____ Other

6. Is there anything you can do to relieve the problem? Yes ___ No _____. If yes, describe

_____. If no, what have you tried to do that has not helped?

7. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending

_____ Lifting _____ Twisting _____ Other

8. Have you had any broken bones? Yes _____ No _____. If yes, please list and give dates

9. List any major accidents you have had other than those that might be mentioned above:

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes _____ No _____. If yes, please explain

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes _____ No _____ Uncertain _____

1 2 . R e m a r k s :

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

Doctor's Signature _____ Date _____