

# 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: \_\_\_\_\_

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

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

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

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

- Major Medical
- Worker's Compensation
- Medicaid
- Medicare
- Auto Accident
- Medical Savings Account & Flex Plans
- 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 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 Health Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

1. Describe your current symptoms (Begin with what bothers you the most) \_\_\_\_\_

2. When did your symptoms begin? \_\_\_\_\_

3. What activities make your symptoms worse? (1) Ice (2) Heat (3) Rest (4) Activity (5) Sitting (6) Standing (7) Medication (8) Other

4. What activities make your symptoms better? (1) Ice (2) Heat (3) Rest (4) Activity (5) Sitting (6) Standing (7) Medication (8) Other

5. What describes the nature of your symptoms?

- (1) Sharp (4) Shooting
- (2) Dull Ache (5) Burning
- (3) Numb (6) Tingling

6. Draw the location of your symptoms on Diagram

7. What describes the severity of your symptoms?

None 1 2 3 4 5 6 7 8 9 10 Severe

8. How are your symptoms changing?

- (1) Getting Better
- (2) Not Changing
- (3) Getting Worse

9. Who else have you seen for your current symptoms?

- (1) No One (3) Medical Doctor (5) This Office

Provider's name: \_\_\_\_\_ (2) Other Chiropractor (4) Physical Therapist (6) Other: \_\_\_\_\_

10. What tests have you had for your symptoms?

- (0) None (1) X-rays date: \_\_\_\_\_ (3) CT Scan date: \_\_\_\_\_
- (2) MRI date: \_\_\_\_\_ (4) Other date: \_\_\_\_\_

11. What other forms of care have you tried for your current complaint?

- (1) Nothing (3) Muscle Relaxer (5) Advil/Tylenol/Aleve, etc (7) Injections
- (2) Pain Medication (4) Ice/Heat (6) Physical Therapy (8) Other: \_\_\_\_\_

12. What do you feel caused your symptoms? (1) Fall (3) Lifting (5) Work  
(2) Car Accident (4) Don't Know (6) Other: \_\_\_\_\_

13. What activities are affected by your symptoms?

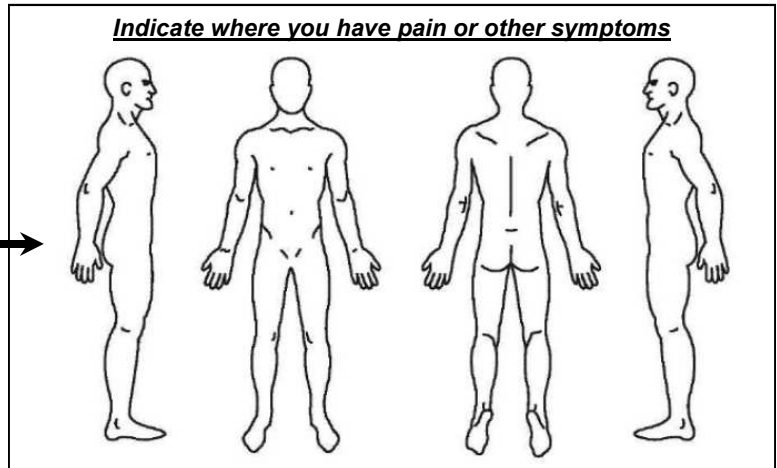
- (1) Work/School (3) Sleeping (5) Driving/Riding in Car (7) Golf (9) Exercising
- (2) Walking (4) Running (6) House Work (8) Yard Work (10) Other \_\_\_\_\_

14. Have you had similar symptoms in the past? (Y) Yes When? \_\_\_\_\_ (N) No

15. If yes, whom did you see? (1) No One (3) Medical Doctor (5) This Office  
(2) Other Chiropractor (4) Physical Therapist (6) Other: \_\_\_\_\_

16. What is your occupation? (1) Professional/Executive (4) Laborer (7) Retired  
(2) White Collar/Secretarial (5) Homemaker (8) Other: \_\_\_\_\_  
(3) Tradesperson (6) F/T Student

17. What type of regular exercise do you perform? (1) None (2) Light (3) Moderate (4) Strenuous



NRP  
RSO  
RTB  
RLAS RRAS  
RLAE RRAE  
RLAH RRAH  
RBB  
RLLB RRLB  
RLLK RRLK  
RLLA RRLA  
REF

For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past.

If you have the conditions listed, place a check in the PRESENT column.

**Many of the following conditions respond to chiropractic and acupuncture**

18.		19.							
PAST	PRESENT			PAST	PRESENT	PAST	PRESENT		
1	( )	( )	Headaches	21	( )	( )	High Blood Pressure	43	( ) ( ) Diabetes
2	( )	( )	Neck Pain	22	( )	( )	Heart Attack	44	( ) ( ) Excessive Thirst/Urination
3	( )	( )	Upper Back Pain	23	( )	( )	Chest Pains	45	( ) ( ) Thyroid Disorder
4	( )	( )	Mid Back Pain	24	( )	( )	Stroke	46	( ) ( ) Smoking/Tobacco Use
5	( )	( )	Low Back Pain	25	( )	( )	Angina	47	( ) ( ) Drug/Alcohol Dependence
6	( )	( )	Shoulder Pain	26	( )	( )	Kidney Stones	48	( ) ( ) Food Allergies
7	( )	( )	Elbow/Upper Arm Pain	27	( )	( )	Kidney Disorder	49	( ) ( ) Depression
8	( )	( )	Wrist Pain	28	( )	( )	Bladder Infection	50	( ) ( ) Frequent Illness
9	( )	( )	Hand Pain	29	( )	( )	Painful Urination	51	( ) ( ) Epilepsy
				30	( )	( )	Loss of Bladder Control	52	( ) ( ) Dermatitis/Eczema/Rash
10	( )	( )	Hip/Upper Leg Pain	31	( )	( )	Prostate Problems	53	( ) ( ) HIV/AIDS
11	( )	( )	Knee/Lower Leg Pain						
12	( )	( )	Ankle/Foot Pain	32	( )	( )	Abnormal Weight Gain/Loss	<b>Females Only</b>	
				33	( )	( )	Loss of Appetite	54	( ) ( ) Hot Flashes
13	( )	( )	Jaw Pain/TMJ	34	( )	( )	Abdominal Pain	55	( ) ( ) Hormone Replacement
				35	( )	( )	Ulcer	56	( ) ( ) Birth Control Pills
14	( )	( )	Joint Swelling/Stiffness	36	( )	( )	Hepatitis	57	( ) ( ) Painful Periods/Cramps
15	( )	( )	Arthritis	37	( )	( )	Liver/Gall Bladder Disorder	58	YES NO Are You Pregnant?
16	( )	( )	Rheumatoid Arthritis					Estimated Due Date _____	
				38	( )	( )	Cancer		
17	( )	( )	General Fatigue	39	( )	( )	Tumor	<b>Other Health Problems</b>	
18	( )	( )	Ringing in Ears	40	( )	( )	Asthma	59	( ) ( ) _____
19	( )	( )	Visual Disturbances	41	( )	( )	Chronic Sinusitis	60	( ) ( ) _____
20	( )	( )	Dizziness	42	( )	( )	Seasonal Allergies	61	( ) ( ) _____

20. Primary Care Physician \_\_\_\_\_ 20b. Date of Last Medical Physical \_\_\_\_\_

21. Indicate if an immediate family member has had any of the following:

(1) Rheumatoid Arthritis (2) Heart Problems (3) Diabetes (4) Cancer (5) Lupus (6) Other: \_\_\_\_\_

22. List all prescription and over-the-counter medications, nutritional/herbal supplements you are taking:

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

23. List all the surgical procedures you have had and times you have been hospitalized:

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

24. Detail any history of trauma to head, neck, or back (automobile accidents, sports injuries, work-related accidents, etc):

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_