

# 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 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 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 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. 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 \_\_\_\_\_

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 \_\_\_\_\_
12. Remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

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

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_