Personal Information

Date: _____ **SSN:** _____

Name: _____ **DOB:** _____

Address: _____
Street City State Zip

Cell Phone: ( ) _____ **Gender: ☐ Male ☐ Female**

Home Phone: ( ) _____ **Email:** _____

Marital Status: ☐ Single ☐ Married ☐ Other

Are you pregnant: ☐ No ☐ Yes, due date _____

Employment: ☐ Not Employed ☐ Employed ☐ Student ☐ Retired

Occupation: _____ **Employer:** _____

Who referred you to our office? _____

Who is your Primary Care Provider? _____

In case of an emergency, who should we contact? _____

Phone #: _____ **Relationship:** _____

Do you have Health Insurance? ☐ No ☐ Yes

Subscribers Name: _____ **DOB:** _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

_____ _____
Signature Date

Health History

Height: _____ **Weight:** _____ **Blood Pressure:** _____

Do you have any previous ILLNESS or MEDICAL PROBLEMS that we need to know about?

☐ High Blood Pressure	☐ High Cholesterol	☐ Diabetes	☐ Heart Problems
☐ Pacemaker	☐ Migraines	☐ Anemia	☐ Arthritis
☐ Asthma	☐ Cancer	☐ Emphysema	☐ Epilepsy
☐ Gout	☐ Kidney Disease	☐ Hernia	☐ Herniated Disc
☐ Liver Disease	☐ Osteoporosis	☐ Stroke	☐ Rheumatoid Arthritis
☐ Thyroid Problems	☐ Multiple Sclerosis	☐ Other _____	

Have you had any SURGERIES? ☐ No ☐ Yes, please list with year it was completed

_____

_____

Are you currently taking any prescription MEDICATIONS? ☐ No ☐ Yes, please list them:

_____

_____

Do you suffer from any ALLERGIES? ☐ No ☐ Yes, please list them:

_____

_____

Have you had any CAR ACCIDENTS, SERIOUS FALLS, or TRAUMAS? ☐ No ☐ Yes, please list them:

_____

_____

Does your MOTHER have any of the following health problems? Is she ☐ Alive ☐ Deceased

☐ Diabetes	☐ Heart Disease	☐ Cancer	☐ Stroke
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Osteoporosis
☐ Arthritis	☐ Rheumatoid Arthritis	☐ Other _____	

Does your FATHER have any of the following health problems? Is he ☐ Alive ☐ Deceased

☐ Diabetes	☐ Heart Disease	☐ Cancer	☐ Stroke
☐ High Blood Pressure	☐ High Cholesterol	☐ Kidney Disease	☐ Osteoporosis
☐ Arthritis	☐ Rheumatoid Arthritis	☐ Other _____	

Health History, cont'd

How many CAFFEINATED BEVERAGES do you consume DAILY? ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10

How many ALCOHOLIC BEVERAGES do you consume WEEKLY? ☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10

What is your current EXERCISE routine? ☐ None ☐ Light ☐ Moderate ☐ Heavy

Do you currently use TOBACCO products? ☐ Current Smoker ☐ Current NON Smoker ☐ Chewing Tobacco

Are you currently experiencing any of the following? (Check all that apply)

☐ Neck Pain	☐ Headaches	☐ Lightheadedness	☐ Changes in Appetite
☐ Upper Back Pain	☐ Migraines	☐ Ringing in Ears	☐ Changes in Bowel Habits
☐ Mid Back Pain	☐ Dizziness	☐ Fainting Spells	☐ Constipation
☐ Lower Back Pain	☐ Stiffness in Neck	☐ Memory Confusion	☐ Diarrhea
☐ Shoulder Pain	☐ Facial Pain	☐ Numbness/Tingling	☐ Heartburn
☐ Arm/Hand Pain	☐ Grinding Teeth	☐ Seizures	☐ Nausea
☐ Knee Pain	☐ Jaw Clicks	☐ Tremors	
☐ Feet/Leg Pain	☐ Head Injury	☐ Weakness	☐ Anxiety
☐ Muscle/Joint Pain	☐ Hoarseness	☐ Vision Blurriness	☐ Depression
☐ Redness of Joints	☐ Lumps in Neck	☐ Loss of Strength	☐ Memory Loss
☐ Stiffness of Joints	☐ Sore Throat		☐ Confusion
☐ Swelling of Joints	☐ Swollen Glands		☐ Nervousness
			☐ Stress
			☐ Easily Irritated

Is there anything else in your medical history that is not mentioned? ☐ No ☐ Yes, please explain:

_____

_____

Signature and Acknowledgment

Patient Name: _____ DOB: _____/_____/_____

Privacy Practices

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides me with the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I may obtain this practice's current Notice of Privacy Practice's upon written request.

Initials _____

Terms of Acceptance

By signing, I acknowledge that I have read and understand this agreement and I will not hold Dr Case or his staff liable for any and all injuries sustained on the premises whether unintentional, accidental, or "acts of God" or any other classification of injury. I understand that with any adjustment or therapy, there is a risk of muscle soreness, stiffness, ache, headaches, pain, dizziness, and other symptoms after treatment and that this is common with chiropractic. I have been advised of these side effects and would like to continue with treatment. I have read all of the terms of acceptance.

Initials _____

Financial Policy

I understand that my insurance is an arrangement between myself and my insurance company, NOT between Case Family Chiropractic and my insurance company. I request that Case Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance company does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Case, that fees will be due and payable immediately. I hereby assign all insurance benefits that may arise to Case Family Chiropractic. A photocopy of this authorization shall be considered effective and valid as the original. I understand that should the status of my account become delinquent, any charges resulting from the collection of said account are incurred by me. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I understand that some or all services provided for me might not be covered by my contract benefits. I understand that all services rendered me are charged directly to me and I am personally responsible for payment. By signing below, I acknowledge that I have read and accepted the financial policy of Case Family Chiropractic.

Initials _____

I have read and understand the Privacy Practices, Terms of Acceptance, and the Financial Policy. These documents have been provided to me and any questions have been answered to my satisfaction.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____