Chiropractic Case History

(PLEASE INFORM FRONT DESK IF YOU ARE CURRENTLY INVOLVED IN A WORK OR AUTO ACCIDENT CASE.)

Name_______________________ Sex: Male Female Date___________

Address_____________________City___________State______Zip________

H. Phone_____________ Work Phone______________ Cell # _________________

Date of Birth__________ Age____ Email address: ___________________________

Marital status: Married Single Divorced Widowed Spouse's name ____________________

# of Children ____ Ages ________________________________

Social Sec.#_____________ Employer______________________________

Occupation ____________________ Job Description ________________________

Have you ever received Chiropractic Care? Yes No If yes, when and Doctor's Name:_________________

Who is your Primary Physician? _______________ How did you hear about us?______________

Complaint / Symptoms

Location of Complaint: ____________________________________

When did you first notice symptoms?__________________________________

Please circle the quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other ____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?__________________

Do you have any numbness or tingling in your body? Where? ______________________________

Please grade pain on scale of 1-10. (10 being worst pain possible) 0 1 2 3 4 5 6 7 8 9 10

How often is your complaint present?_________________How long does it last? ____________

Does anything aggravate the complaint? ______________________________

Does anything make the complaint better?______________________________

Do you experience headaches? Yes No If yes, how often? ______________________

Health History

What treatment(s) have you already received for this condition?___________________________

Estimated dates of when you received the above treatment(s):__________________________

Name of other doctor(s) who have treated you for this condition:______________________

A. Previous illnesses, injuries, or trauma you've had in your life:____

____

Have you ever broken any bones? Which? ____

B. List any allergies you have: ____

C. Medications:

Medication	Reason for taking
______________________________	______________________
______________________________	______________________
______________________________	______________________

D. Surgeries:

Date	Type of Surgery
______________________	______________________________
______________________	______________________________
______________________	______________________________

E. FOR WOMEN ONLY--Pregnancy Release:

Are you pregnant? Yes No Date of the beginning of your last menstrual period:______________________

This is to certify that to the best of my knowledge I am not pregnant, and the doctor and his associates have my permission to perform a x-ray evaluation if needed. I have been advised that x-ray can be hazardous to an unborn child.

Signature______________________________ Date______________________

F. Family Health History:

Associated health problems of relatives: ____

____

Deaths in immediate family due to illness:

Cause of parents or siblings death	Age at death
______________________________	______________________
______________________________	______________________
______________________________	______________________

Social History

A. Lifestyles (hobbies, level of exercise, diet):____

____

Do you smoke?__________ If yes, how much per day?______________ How much alcohol consumed weekly?______________

What vitamins do you currently take?____

Insurance Information

Is the insurance in your name?_________ Name of insurance company ____

If no, please give the following information:

Name of insured_____________________________________ Date of Birth________________ Sex: Male Female

Relationship to patient______________________________ Social Security # ____

Address____ City_______________________ State_______ Zip_________________

Phone #___________________________ Employer_______________________________ Work Phone #______________________

If on MEDICARE, do you have a supplemental insurance plan? _________ If yes, name of insurance ______________________

PLEASE READ THE FOLLOWING:

Most insurance policies cover chiropractic/medical care, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for chiropractic/medical care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage. And we will bill your insurance company in a timely manner.

If you suspend or terminate your care at any time, your portion of all charges for professional services are immediately due and payable to this office. All services rendered by this office are charged to you. You ultimately will be personally responsible for payment, regardless of your insurance coverage.

Payment Arrangements

Payment for services in this office, is due on the day services are rendered.

AUTHORIZATION:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize x-rays to be taken if the chiropractor feels it is necessary for my evaluation.

I authorize the chiropractor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care, to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to the chiropractor any insurance benefits otherwise payable to me.

I understand that my insurance company does not guarantee payment and/or my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If I choose not to file my service with my insurance company, I take full responsibility for all charges for services rendered in this office.

Signature of Patient (or parent if a minor)_____________________________________ Date______________________________