

# Chiropractic Case History/New Patient Information

Date: \_\_\_\_\_

Doctor: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How many children? \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Family Medical Doctor: \_\_\_\_\_

Please check all insurance coverages that may be apply to patient:

- 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.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

**HISTORY OF PRESENT AND PAST ILLNESS:**

Chief Complaint: Purpose of this appointment: \_\_\_\_\_

Date symptoms appeared or accident happened: \_\_\_\_\_

Is this due to: Auto \_\_\_ Work \_\_\_ Other \_\_\_\_\_

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: \_\_\_\_\_

Do you have a history of stroke or hypertension? \_\_\_\_\_

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (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? \_\_\_\_\_

Do you have any allergies to any medications?  Yes  No

If yes, describe: \_\_\_\_\_

Do you have any allergies of any kind?  Yes  No

If yes, describe: \_\_\_\_\_

Do you have any Congenital Condition? \_\_\_ Yes \_\_\_ No If YES, Describe \_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**. (N = Now P = Previously)

Headaches		Loss of Balance	
Neck Pain		Fainting	
Stiff Neck		Loss of smell	
Sleeping Problems		Loss of taste	
Back Pain		Unusual Bowel Patterns	
Nervousness		Cold feet	
Tension		Cold hands	
Irritability		Arthritis	
Chest Pains/Tightness		Muscle Spasms	
Dizziness		Frequent Colds	
Shoulder/Neck/Arm Pain		Fever	
Numbness in Fingers		Sinus Problems	
Numbness in Toes		Diabetes	
High Blood Pressure		Indigestion Problems	
Difficulty Urinating		Joint Pain/Swelling	
Weakness in Extremities		Menstrual Difficulties	

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_ Doctor \_\_\_\_\_

Breathing Problems		Weight Loss/Gain	
Fatigue		Depression	
Lights Bother Eyes		Loss of Memory	
Ears Ring		Buzzing in Ears	
Broken Bones/Fractures		Circulation Problems	
Rheumatoid Arthritis		Seizures/Epilepsy	
Excessive Bleeding		Low Blood Pressure	
Osteoarthritis		Osteoporosis	
Pacemaker		Heart Disease	
Stroke		Cancer	
Ruptures		Coughing Blood	
Eating Disorder		Alcoholism	
Drug Addiction		HIV Positive	
Gall Bladder Problems		Depression	
Ulcers			

**SOCIAL HISTORY**

Please indicate beside each activity whether you engage in it:  
 OFTEN= "O"    SOMETIMES= "S"    NEVER= "N"

Vigorous Exercise		Family Pressures	
Moderate Exercise		Financial Pressures	
Alcohol Use		Mental Stresses	
Drug Use		Other _____	
Caffeine Use		Other _____	
High Stress Activity			

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I certify the information provided is accurate to the best of my knowledge:

Name of Patient \_\_\_\_\_

Signature of Patient/Legal Guardian \_\_\_\_\_

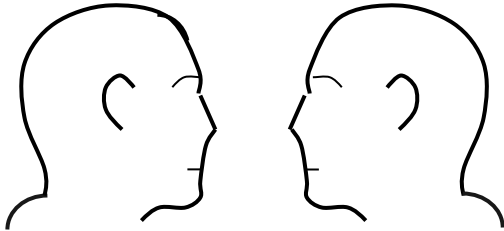
Date \_\_\_\_\_

DOCTOR \_\_\_\_\_  
 DATE OF VISIT \_\_\_/\_\_\_/\_\_\_ Patient \_\_\_\_\_ Age \_\_\_\_\_  
**Check ONE:** \_\_\_\_\_ INITIAL EXAMINATION \_\_\_\_\_ RE-EVALUATION \_\_\_\_\_ NEW CONDITION  
 FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms \_\_\_\_\_  
 FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SUBJECTIVE PAIN ASSESSMENT**

**Right**

**Left**

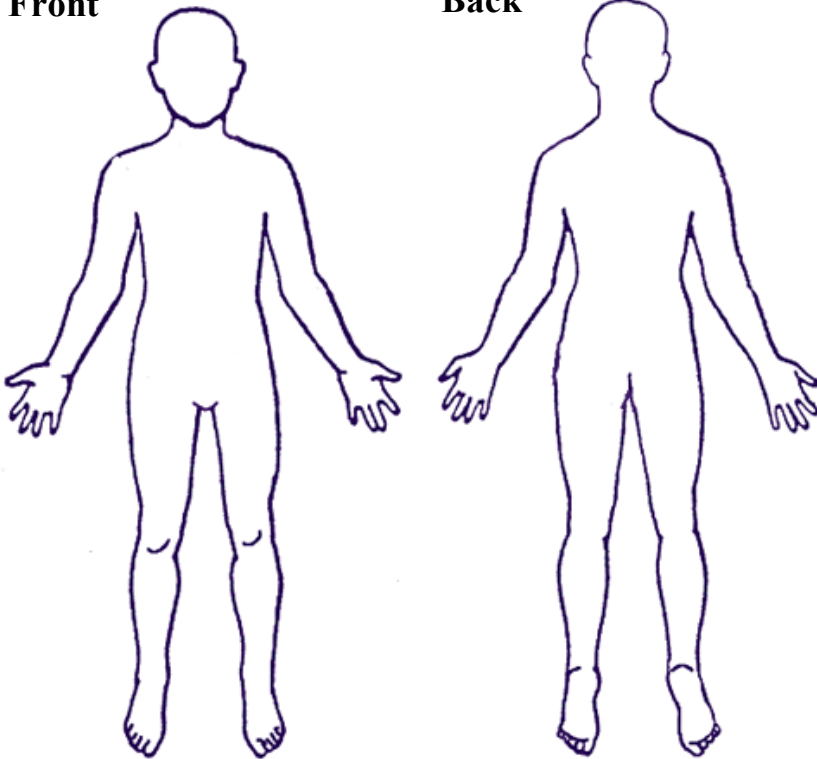


**RATE YOUR PAIN**

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

**Front**

**Back**



- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

**PAIN SCALE:** Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+  
 NONE LITTLE MEDIUM SEVERE  
 EXCRUCIATING

**PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE**

**DATE**

\_\_\_\_\_

\_\_\_\_\_