NATURAL CHIROPRACTIC HEALING

Chiropractic Case History/Patient Information

Name: _____ Social Security#:_____ Home Phone: _____
Address: _____City: _____ State: _____ Zip: _____
E-mail Address: _____Fax#: _____ Phone: _____
Age: _____ Birth Date: ___/___/_____ Race: _____ Marital: M S W D
Occupation: _____ Employer: _____
Employers Address: _____Office Phone: _____
Spouse: _____Occupation: _____Employer:_____
How many children? _____ Names and ages of children: _____
_____
Name of nearest relative: _____ Address: _____Phone: _____
How were you referred to our office? _____
Family Medical Doctor: _____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS:
Chief Complaint: Purpose of this appointment: _____
Date and 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 of lost work? _____ Date of last physical examination: ___/___/_____ Abnormal Findings_____

PAST MEDICAL HISTORY
Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that may apply to you)

___Broken or Fractured Bones	___Osteoarthritis	___Eating Disorder
___Circulatory Problems	___Epilepsy	___Alcoholism
___Rheumatoid Arthritis	___Pace Maker	___Drug Addiction
___Seizures/Convulsions	___Strokes	___HIV Positive
___Congenital Disease	___Cancer	___Gall Bladder
___Excessive Bleeding	___Ruptures	___Depression
___High/Low Blood Pressure	___Coughing Blood	___Ulcers

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: _____

List medications (Rx and OTC) you are currently taking and why:_____
_____
_____
List any vitamins/ supplements you are taking and why:_____
_____

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:_____

Turn page over…

Do you have any other health issues or concerns that our staff should be made aware of? _____
_____
_____

SOCIAL HISTORY:
Do you drink alcoholic beverages?_____ If so, how much per week?_____ Types_____
Do you use tobacco products? _____Do you smoke? ____ if so, packs per day _____how long? _____
Do you drink caffeine? _____ If so, how much per day? _____Types_____
Do you exercise?_____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
How much time during the day (at home or at a job away from home) do you spend? Lifting _____ sitting _____
bending_____ walking_____ standing_____ working at a computer _____

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FAMILY HISTORY:
Parents:
Father: living ____deceased ____ Current age if living: _____Cause and age at death, if deceased _____
Mother: living ___deceased _____ Current age if living: _____ Cause and age at death, if deceased _____

Check if applicable to you: _____As an adopted child, little is known of my birth parents or family.

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, and **B**rother):

__Alcoholism	__Cancer	__High Blood Pressure
__Anemia	__Diabetes	__High Cholesterol
__Arteriosclerosis	__Emphysema	__Multiple Sclerosis
__Arthritis	__Epilepsy	__Osteoporosis
__Asthma	__Glaucoma	__Stroke
__Bleeds Easily	__Heart Disease	__Thyroid Disease

__Other (not listed) _____

PLEASE CHECK ANY AND ALL INSURANCE COVERAGE THAT MAY BE APPLICABLE IN THIS CASE:
__ Major Medical __ Medicare __Workers Comp __Auto Accident __Medical/ Health Savings Account & Flex Plans

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to this chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors 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.

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. For more detailed information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk.

I understand and agree to allow this chiropractic office to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any health or coverage changes.

Patients Signature: _____ Date: _____

Guardians Signature Authorizing Care: _____ Date: _____