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

Occupation:_____ Employer:_____

Employer's 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 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:_____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that 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
__A 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:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ❒ Yes ❒ No

If yes, describe:_____

Front and Back →

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?___ If so, how much per week?_____
Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY:

Parents:

Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____ (check one)

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

Do you have any family members who suffer from the same condition you do? If so, please list:_____

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

Tuberculosis____
Diabetes ____
Stroke ____
Arthritis_____
Other _____

Cancer____
Asthma____
Kidney Disease____
Liver Disease ____

Mental Illness____
Heart Disease ____
Lung Disease____

Please check any and all insurance coverage that may be applicable in this case:
π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

PAIN INFORMATION

To your knowledge, what caused you to have the pain you are experiencing today?_____

_____

_____

What activities make your pain worse (**examples: walking, sitting, bending**):_____

_____

What activities make your pain better: _____

_____

Have you used (circle one) **Ice** **Heat** **Medication** **Pain Relieving Ointments**

Is your pain worse in the (circle one) **Morning** **Evening** **No Difference**

Please circle any of these additional symptoms you may be experiencing:

Headaches **Constipation** **Sensitivity to Light** **Fainting** **Pins & Needles**
Tension **Migraines** **Cramps** **Ringing in Ears** **Loss of Appetite**
Nausea **Grind/Grate** **Nervousness** **Swelling** **Chest Pain** **Memory Loss**
Hearing Loss **Heartburn** **Gas** **Numbness** **Spasms** **Swollen Ankle**
Shortness of Breath **Loss of Sleep** **Indigestion** **Diarrhea** **Irritability** **Stiffness**

Please circle any of these activities that may be difficult due to the pain you are experiencing:

Child Care **Hobbies** **Sitting** **Eating** **Gardening** **Yard Work**
Swimming **Weight Lifting** **Sleeping** **Driving** **Standing** **Shopping**
Exercising **Paperwork** **Household Chores** **Walking** **Playing with Child**
Up/Down Stairs **Social Acts** **Computer Work** **Sports** **Gym Class**
Reading **Work** **Dancing** **Religious Events** **Jogging/Running**

BODY CHART

REASON FOR VISIT

Name: _____ Date: __/__/__ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..

Reason for visit: ❑ Work Accident ❑ Sports Injury ❑ Car Accident ❑ Trauma/Injury ❑ Chronic Pain ❑ Routine Adjustment

Explain what happened: _____

When did condition begin? __/__/__ Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine Have you had this or similar conditions in the past? ❑ Yes ❑ No

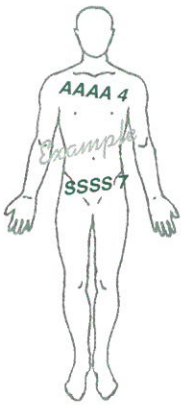
If so, please explain: _____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

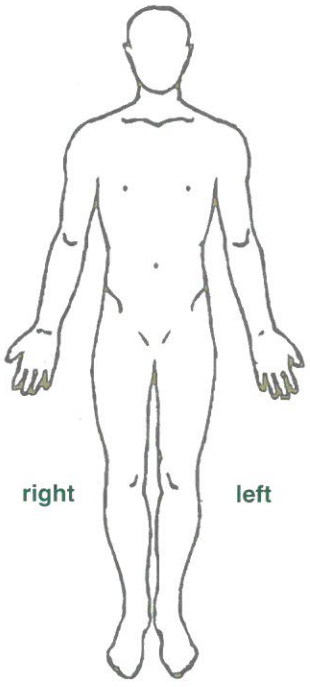
Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



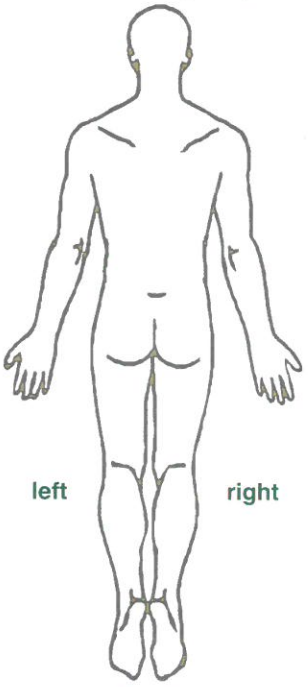
Example

Right



right left

Front



left right

Back

Left

DOCTOR'S NOTES

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE_____

PATIENT:_____

EMPLOYER:_____

CLAIM/GROUP:_____

INSURANCE SS#/ID#_____

I HEREBY INSTRUCT AND DIRECT THE PAYMENT OF ALL PROFESSIONAL OR MEDICAL EXPENSE ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICE TO:

_____

As payment for professional services rendered. THIS IS A DIRECT ASSIGNMENTOF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, In a current manner, and balance of said professional service charges over and above this insurance payment.

If my current police prohibits direct payment to doctor, then I hereby also instruct and direct to make out the check to me and mail it a follows:_____

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company ,adjuster or attorney involved in this case.

DATE x_____ INSURED x_____

PATIENT NAME:_____

CELL PHONE NUMBER:_____

CELL PHONE CARRIER:_____

(AT&T,VERIZON)

EMAIL ADDRESS:_____

I,_____, give permission to the staff of Taylor Family Chiropractic to send texts and/or emails to my phone or email account.