

# Health History

## Chiropractic Case History/Patient Information

In-office use: Patient # \_\_\_\_\_ Doctor \_\_\_\_\_

Please print this form from your computer. You can then sign the form and bring it with you to your first appointment. This form will not be submitted via the Internet, so security is not an issue.

Date \_\_\_\_\_

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Race\* \_\_\_\_\_

Marital:  M  S  W  D # of children? \_\_\_\_\_

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

Employer's Address \_\_\_\_\_ Office Phone \_\_\_\_\_

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

Name of Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_

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

Primary Doctor \_\_\_\_\_

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

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 \_\_\_\_\_

What surgeries have you had? (include dates) \_\_\_\_\_

Serious illnesses (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? \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case.

Major Medical  Worker's Compensation  Medicaid  Medicare  Auto Accident 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

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

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

1. What is your major symptom? \_\_\_\_\_

2. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_

How did it originally occur? \_\_\_\_\_

Has it become worse recently?  Yes  No  Same  Better  Gradually Worse

If yes, when and how? \_\_\_\_\_

3. How frequent is the condition?  Constant  Daily  Intermittent  Night Only

How long does it last?  All Day  Few Hours  Minutes

4. Are there any other conditions or symptoms that may be related to your major symptom?  Yes  No

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

Are there other unrelated health problems?  Yes  No

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

5. Describe the pain:  Sharp  Dull  Numbness  Tingling  Aching  Burning  Stabbing  Other

6. Is there anything you can do to relieve the problem?  Yes  No If yes, describe \_\_\_\_\_

If no, what have you tried to do that has not helped? \_\_\_\_\_

7. What makes the problem worse?  Standing  Sitting  Lying  Bending  Lifting  Twisting  Other

8. Have you had any broken bones?  Yes  No If yes, please list and give dates: \_\_\_\_\_

9. List any major accidents you have had other than those that might be mentioned above: \_\_\_\_\_

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present?  Yes  No

If yes, please explain: \_\_\_\_\_

11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  Yes  No  Uncertain

12. Do you have any comments or further information that may assist the doctor in evaluating your condition and recommending treatment? \_\_\_\_\_

\_\_\_\_\_

**In-office use:**

Doctor's Remarks: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_