

Chiropractic Case History/Patient Information

Date: _____ Patient # _____ Doctor: _____

Name: _____ Social Security # _____ Mobile #: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Home Phone #: _____

Age: _____ Birth Date: _____ Race: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Spouse: _____ How many Children: _____ Names & Ages: _____

Emergency Contact: Name: _____ Phone Number: _____

Whom may we thank for referring you to our clinic? _____

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: _____

PAST MEDICAL HISTORY

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

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Strokes	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> A Congenital Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gall Bladder
<input type="checkbox"/> Ruptures	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Depression

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

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: _____

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? _____

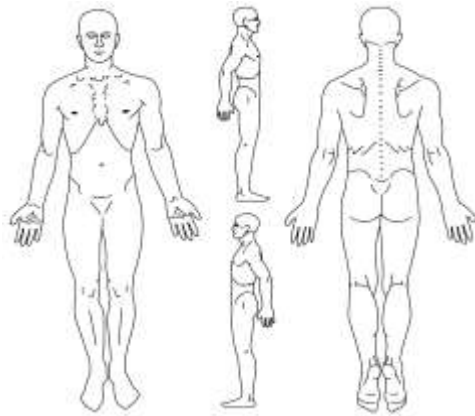
What are your hobbies? _____

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 _____

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. 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? _____
4. How frequent is the condition? Constant Daily Intermittent Night Only
 How long does it last? All Day Few Hours Minutes
5. Do you have any other conditions or symptoms that you feel may be related to your major symptom? No Yes
 If yes, describe: _____
 Are there other unrelated health problems? No Yes, describe _____
6. Describe the pain. Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____
7. Is there anything you can do to relieve the symptoms? Yes No
 If yes, describe: _____
 If no, what have you tried to do that has not helped? _____
8. What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: _____
9. Have you had any broken bones? No Yes If yes, please list and give dates: _____
10. List any major accidents you have had other than those that may be mentioned above. _____

11. To your knowledge, have you had any diseases, major illnesses, or injuries in the past or the present that are not indicated on this form? No Yes, describe: _____
12. **WOMEN ONLY:** Are you pregnant or is there any possibility that you may be pregnant? Yes No Uncertain
13. Please mark the location of your symptoms in the appropriate areas on the images below.



14. On the line below, please draw an "X" to indicate level of problem.

no symptoms

unbearable symptoms

Doctor's Signature _____ Date _____

FAMILY HISTORY:

Father: living ___ deceased ___ Cause of death and age at death if deceased: _____

Mother: living ___ deceased ___ Cause of death and age at death if deceased: _____

Do you have any family members who suffer from the same condition you do?

If so, please list: _____

Please list any major diseases that tend to "run in" your family: _____

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

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans Other

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.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

HIPAA:

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of West Omaha Chiropractic Clinic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice. I give consent to West Omaha Chiropractic to the use and disclosure of my PHI for the purpose of providing treatment to me, for purposes related to payment of services rendered to me, and for the Practice's general healthcare operations.

Patient's Signature: _____ Date: _____

CONSENT TO TREAT:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results cannot be guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocation and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked for in a thorough examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare are estimated to occur between one in a million and one in five million cervical adjustments. The other complications are also generally described as rare.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Patient's Signature: _____ Date: _____