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

Occupation:_____ Employer:_____

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)

__Broken or Fractured Bones	__Osteoarthritis	__Osteoporosis
__Circulatory Problems	__Epilepsy	__Alcoholism
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction
__Seizures/Convulsions	__Strokes	__HIV Positive
__A Congenital Disease	__Cancer	__Gall Bladder
__Ruptures	__High/Low Blood Pressure	__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:

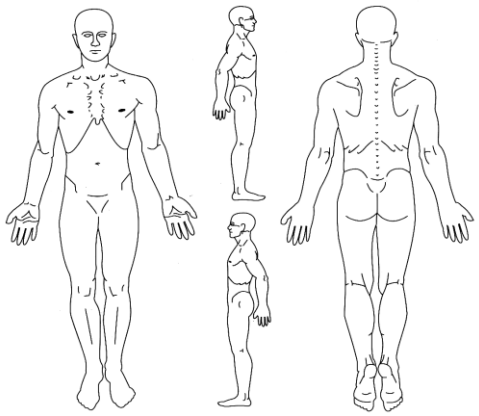
_____

_____

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 children?_____ If yes, what are their ages?_____

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:_____