

# Chiropractic Case History

Date \_\_\_\_\_

Patient # \_\_\_\_\_

Doctor \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Race \_\_\_\_\_ Marital: M S W D How many children? \_\_\_\_\_

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

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

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

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

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

Family Medical Doctor \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_

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 understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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 \_\_\_\_\_

**Chiropractic Case History/Patient Information**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. What is your major symptom? \_\_\_\_\_  
How did it happen? \_\_\_\_\_
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. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

\_\_\_\_\_

Please place an "X" on the line above to indicate your level of problem.

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

