

# Chiropractic Case History/Patient Information

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

## PERSONAL INFORMATION

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

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

E-mail address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Birth date: \_\_\_\_\_

Marital: M S W D Occupation: \_\_\_\_\_

Employer name, address, phone #: \_\_\_\_\_

Spouse/other: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of person(s) we can discuss your care/account with (name, address, phone #)? \_\_\_\_\_

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

# of children? \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

Who may we thank for your referral to our office? \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_ If yes: Physicians name, address, phone #: \_\_\_\_\_

## HISTORY OF PRESENT CONDITION(S)

1) Chief Complaint(s): \_\_\_\_\_

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

3) Is this due to: Auto Work Other \_\_\_\_\_

4) Have you ever had the same or a similar condition? Yes No If yes, when and describe: \_\_\_\_\_

5) Days lost from work: \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

6) What does this prevent you from doing or enjoying? \_\_\_\_\_

7) Has it become worse recently? Yes No If yes, when & how? \_\_\_\_\_

8) How frequent is the condition? Constant Daily Intermittent Night Only

9) How long does it last? All Day Few Hours Minutes

10) Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

11) What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting

12) Is there anything you have done that relieves the problem? If so please describe: \_\_\_\_\_

What have you tried that has **NOT** relieved the problem? \_\_\_\_\_

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

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

**PAST MEDICAL HISTORY**

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <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"/> Excessive bleeding        | <input type="checkbox"/> Ruptures       | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> High/Low Blood Pressure   | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers          |

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 allergies to any medications? Yes No

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

Do you have allergies of any kind? 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? Yes No If so, how much per week? \_\_\_\_\_

Do you use any tobacco products? Yes No If so, packs/dips per day: \_\_\_\_\_

Do you take vitamin supplements? Yes No If so, please list: \_\_\_\_\_

Do you consume caffeine? Yes No If so, how much per day: \_\_\_\_\_

Do you exercise? Yes No If so, what is the frequency & type of exercise? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

What percentage of time during the day (at home or at work) do you spend:  
Lifting \_\_\_\_\_ Sitting \_\_\_\_\_ Bending \_\_\_\_\_ Working at a computer \_\_\_\_\_

**FAMILY HISTORY**

Father: Living Current age: \_\_\_\_\_ Deceased Cause of death & age: \_\_\_\_\_

Mother: Living Current age: \_\_\_\_\_ Deceased Cause of death & age: \_\_\_\_\_

Are you adopted (sometimes as an adopted child, little is known of birth parents or family). Yes No

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 _____ | Cancer _____         | Mental Illness _____ |
| Diabetes _____     | Asthma _____         | Heart Disease _____  |
| Stroke _____       | Kidney Disease _____ | Lung Disease _____   |
| Arthritis _____    | Liver Disease _____  |                      |
| Other _____        |                      |                      |

**INSURANCE** (Please present the front desk with a copy of your current insurance card(s)) Please circle any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Do you have a Medical Savings Account & Flex Plans? YES NO

**INSURANCE AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to Gamble Chiropractic Clinic. I authorize Gamble Chiropractic Clinic to release all information necessary to communicate with personal physicians and other healthcare providers and payers 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.

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

**INFORMED CONSENT/TREATMENT AUTHORIZATION**

I, the undersigned, have been informed by the participating treating Doctor of Chiropractic (D.C.) listed below, that he/she is a licensed chiropractor, and having been informed by such Doctor as to the benefits and potential risks of chiropractic treatment, hereby consent to such treatment.

I hereby agree to hold Gamble Chiropractic Clinic and their affiliates, all associated sanctioned events and/or endorsement levels in Gamble Chiropractic Clinic; any and all associated co-sponsorships of any level or participation; free and harmless from any liability, claims, demands, or suits for damages from any injury or complications whatever, which may result from such treatment. This document is binding and the parties hereto intend this Informed Consent Wavier and Authorization to Treat to be binding and inure to the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complication arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

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

**PATIENT HEALTH INFORMATION CONSENT FORM (HIPPA)** We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

- 1) The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
- 2) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- 3) A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- 4) The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- 5) For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
- 6) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- 7) If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature

Date