

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

**Name:** (Last, First MI) \_\_\_\_\_ **Preferred Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_ **Mobile Carrier:** \_\_\_\_\_ **Work:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Gender:** M / F **Marital Status:** Married / Other / Single  
**Social Security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Student Status:** Full Student / Part Student / Non-Student  **Employed** **Employer:** \_\_\_\_\_  
**\*Referred By:** \_\_\_\_\_

**Ethnicity:** Hispanic or Latino / Other **Preferred Language:** \_\_\_\_\_  
**Race:** Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White **Smoking Status:** Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

**Full Name:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_  
**Home:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_ **Doctor's Phone:** \_\_\_\_\_  
**Relationship:** Child / Parent / Spouse / Other: \_\_\_\_\_

## FINANCIAL INFORMATION

Insurance  Worker's Comp  Self-Pay (Cash)  Personal Injury/Auto  Other (please explain): \_\_\_\_\_

### PRIMARY INSURANCE

**Name:** \_\_\_\_\_  
**Relation to Insured:** Self / Spouse / Parent / Child / Other  
*Other than Self:*  
**Insured's Name:** \_\_\_\_\_ **Gender:** M / F  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

### SECONDARY INSURANCE

**Name:** \_\_\_\_\_  
**Relation to Insured:** Self / Spouse / Parent / Child / Other  
*Other than Self:*  
**Insured's Name:** \_\_\_\_\_ **Gender:** M / F  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Who is responsible for payment?** Self / Other - (*Relationship*) \_\_\_\_\_

*Other than Self:*

**Full Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

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

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

**Patient No:** \_\_\_\_\_

# PEDIATRIC CASE HISTORY

## HISTORY OF CURRENT CONDITION

Describe Major Complaint: \_\_\_\_\_

Began When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Describe how this began: \_\_\_\_\_

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

How frequent is the complaint present? Off & On / Constant

Does anything make the complaint better? \_\_\_\_\_

Does anything make the complaint worse? \_\_\_\_\_

Which daily activities are being affected by this condition? (Describe) \_\_\_\_\_

### For this CURRENT condition, have you:

• Received any other treatment? None / DC / MD / PT / Massage / ER / Other: \_\_\_\_\_ Where? \_\_\_\_\_

• Had any previous Surgery or Interventions in this area? (Describe) \_\_\_\_\_

• Taken any Medications? OTC / Prescriptions \_\_\_\_\_

• Had any diagnostic testing? X-rays / MRI / CT / Other: \_\_\_\_\_ When and Where? \_\_\_\_\_

Describe any Secondary Complaints: \_\_\_\_\_

## HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

### Medications:

Allergies to Medications: NONE (List) \_\_\_\_\_

Current Medications: NONE  
(Over-the-counter or Prescription.) \_\_\_\_\_

### Past Health History: (Please list any past...)

Surgeries – Date, Type, and Reason: NONE

Major Injuries/Traumas: NONE \_\_\_\_\_

Major Hospitalizations: NONE \_\_\_\_\_

### Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

Patient No: \_\_\_\_\_

### Prenatal History: Home / Birthing Center / Hospital

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

Interventions: NONE / Forceps / Vacuum / C-Section

Complications: NONE / \_\_\_\_\_

Medications during pregnancy: NONE / \_\_\_\_\_

### Feeding and Development History:

Breast fed:  No  Yes - How long? \_\_\_\_\_

Formula:  No  Yes - What type? \_\_\_\_\_

Food allergies or intolerances? :  No  Yes

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

Rolling over:  No  Yes

Sitting:  No  Yes

Crawling:  No  Yes

Walking:  No  Yes

Sleep: Hours/night \_\_\_\_\_ Sleep well:  No  Yes

Childhood diseases:  None  Chicken Pox  Measles

Meningitis  Mumps  Whooping Cough  Rubella

Other: \_\_\_\_\_

Has child been vaccinated? :  No  Yes

Any adverse reactions? :  No  Yes \_\_\_\_\_

### Social and Occupational History:

Level of Education Completed: \_\_\_\_\_

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- Recent Weight Change
Fever
Fatigue
None in this Category

Musculoskeletal:

- Low Back Pain
Mid Back Pain
Neck Pain
Arm Problems
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
None in this Category

Neurological:

- Numbness or tingling sensations
Loss of Feeling
Dizziness or light headed
Frequent or Recurrent Headaches
Convulsions or seizures
Tremors
Stroke
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
None in this Category

Gastrointestinal:

- Loss of Appetite
Blood in Stool
Change in Bowel Movements
Painful Bowel Movements
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, Nose and Throat:

- Bleeding gums / mouth sores
Bad Breath or bad taste
Dental Problems
Swollen throat or voice change
Swollen glands in neck
Ringing in the ears
Ear - Ache/Ringing/Drainage
Sinus / Allergy problems
Nose Bleeds
Hearing Loss
Other:
None in this Category

Endocrine, Hematologic, and

Lymphatic:

- Thyroid problems
Diabetes
Excessive Thirst or urination
Cold Extremities
Heat or Cold intolerance
Change in hat or glove size
Dry skin
Glandular or hormone problem
Swollen Glands
Anemia
Easily Bruise or Bleed
Phlebitis
Transfusion
Immune system disorder
Other:
None in this Category

Skin and Breasts:

- Rash or Itching
Change in Skin Color
Change in hair or nails
Non-healing sores
Change of appearance of a mole
Breast Pain
Breast Lump
Breast Discharge
Other:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

- Infertility
Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

Blank lines for recording pregnancy outcomes and dates.

Comments:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature Date

Treating Doctor Signature Date

Patient No:

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

**AUTHORIZATION:** By signing below you authorized this office/provider to complete a consultation and examination on the above.

**AUTHORIZATION FOR X-RAY WITH RELEASE:** By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.

**ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS:** By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arrangement between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.

**CMS-1500 HEALTH INSURANCE CLAIM FORM:** By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.

**ACKNOWLEDGEMENT OF TREATMENT PLAN:** By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

**ACKNOWLEDGEMENT:** By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

Signature of Patient: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

**Consent for Chiropractic Services**

**By reading below I have been made aware:**

1. The process of delivering a “Chiropractic Adjustment (manipulation)” may be performed **manually, with a table mechanism, or with an instrument** to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies and/or Procedures” may be applied by the chiropractor or by staff under the chiropractor’s direction or supervision incorporating the use of **light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;**
3. That on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
4. That the chiropractor has made no guarantee of a positive outcome from treatment.

**Additionally:**

1. I have been afforded ample opportunity for questions and answers.

**Therefore by signing below:**

**I consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

**I consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_