Chiropractic Case History/Patient Information

Date: ___________________ **Name of Primary Health Insurance:** ____

Name: ____ Social Security #_______________________Home Phone: _____________________

Address: ____City:_____________________________ State: _________ Zip: _____________

E-mail Address: ____ Fax #______________________ Cell Phone: ______________________

Age: ___________ Birth Date: _________________ Race: _____________________________ Marital: M S W D Gender: M F

Occupation: ______________________________ Employer: ____________________________________ Office Phone: _________________________

Spouse: ______________________________________ Birth Date: ___________________ Employer: ______________________________________

How many children? __________ Names and Ages of Children: ____

Name of Nearest Relative: ____________________________ Address: ______________________________________Phone:___________________

Family Medical Doctor: ____

May we have your permission to update your medical doctor regarding your care at this office? Yes No

How did you hear about our office? ____

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:
____

____

Days lost from work: _______________________ Date of last physical examination:__________________________

List all prescription, over-the-counter medications, and nutritional/herbal supplements you are taking:
____

Have you ever seen a chiropractor before? Yes No If yes, Name of Dr./Location: ____

Date of last visit: _______________ (approx)

Do you have any allergies to any medications? Yes No

If yes, describe: ____

Do you have allergies of any kind?

Family Diseases (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

___ Tuberculosis ___ Cancer ___ Mental Illness ___ Diabetes ___ Asthma
___ Stroke ___ Kidney Disease ___Lung Disease ___ Arthritis ___Liver Disease
___ Heart Disease ___ Other: ___________________________

PAST MEDICAL HISTORY

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Yes No 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, please describe: ____

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 consume caffeine? ________ If so, how much per day: ____
What are your hobbies? ____
What % of time during the day (at home or at your job) do you spend: lifting ______ sitting ______ bending ______ in front of the computer ______
What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Strenuous

---

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.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: ____ Date: ________________

Guardian's Signature Authorizing Care: ____ Date: ________________

Patient Health Questionnaire – PHQ

Patient Name____ **Date** ____ / ____ / ____

1. Describe your symptoms ____

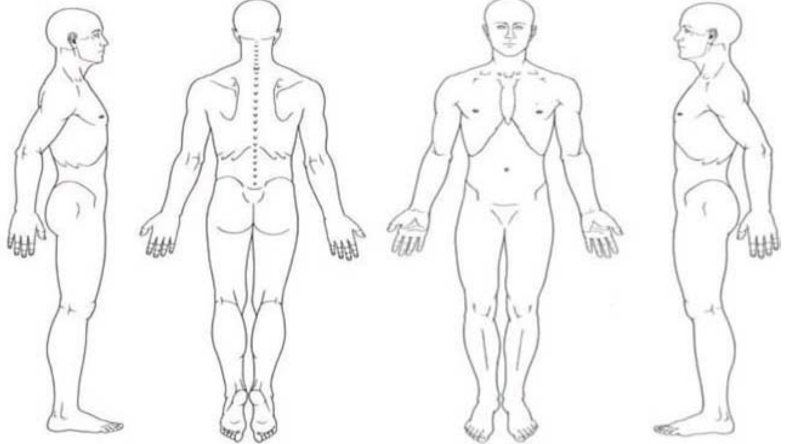
____

a. When did your symptoms start? ____

b. How did your symptoms begin? ____

2. How often do you experience your symptoms?
- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



3. What describes the nature of your symptoms?
- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?
- ① Getting better
- ② Not changing
- ③ Getting worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms: None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. For each of the conditions listed below, place a check in the past column if you have had the condition in the past and place a check in the present column if you have the condition presently. Circle L for Left and R for Right where applicable.

Past	Present	
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain L R
O	O	Elbow/Upper Arm Pain L R
O	O	Wrist Pain L R
O	O	Hand Pain L R
O	O	Hip/Upper Leg Pain L R
O	O	Knee/Lower Leg Pain L R
O	O	Ankle/Foot Pain L R
O	O	Ulcer
O	O	Jaw Pain L R
O	O	Joint Swelling/Stiffness
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	Muscular Incoordination
O	O	Visual Disturbances
O	O	Dizziness
O	O	Numbness/Tingling

Past	Present	
O	O	High Blood Pressure
O	O	Heart Attack
O	O	Chest Pains
O	O	Stroke
O	O	Angina
O	O	Kidney Stones
O	O	Kidney Disorders
O	O	Bladder Infection
O	O	Painful Urination
O	O	Loss of Bladder Control
O	O	Prostate Problems
O	O	Abnormal Weight Gain/Loss
O	O	Loss of Appetite
O	O	Abdominal Pain
O	O	Osteoarthritis
O	O	Hepatitis
O	O	Liver/Gall Bladder Disorder
O	O	Cancer
O	O	Tumor
O	O	Asthma
O	O	Chronic Sinusitis
O	O	Broken/Fractured Bones
O	O	Circulatory Problems
O	O	Seizures/Convulsions
O	O	A Congenital Disease
O	O	Excessive Bleeding

Past	Present	
O	O	Diabetes
O	O	Excessive Thirst
O	O	Freq. Urination
O	O	Ruptures
O	O	Coughing Blood
O	O	Eating Disorder
O	O	Pace Maker
O	O	Allergies
O	O	Depression
O	O	Systemic Lupus
O	O	Epilepsy
O	O	Dermatitis/Rash
O	O	HIV/AIDS
O	O	Drug/Alcohol Dependence
O	O	Smoking/Use Tobacco Prod.

Females Only

Past	Present	
O	O	Hormonal Rep.
O	O	Pregnancy
O	O	Birth Control

Other Health Problems

Past	Present	
O	O	
O	O	

Patient Signature____ **Date** ____ / ____ / ____