

Chiropractic Case History/Patient Information

Date: _____

Patient # _____

Doctor Hushower

Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Would you like to receive appointment reminders via email or Text? Please provide your email address and Cell information so that we may be able to do this. Social Security #: _____

E-mail address: _____ Cell Phone: _____ Cell Carrier: _____

Preferred Method of Contact (Home Phone, Cell Phone, etc..) _____

Age: _____ Birth Date: _____ Race: _____ Gender: M F Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____ City, State _____

When doctors work together it benefits you.

May we have your permission to update your medical doctor regarding your care at this office? _____

May we have your permission to e-mail you with our events and specials going on for each month? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto Accident ___ Work Accident ___ 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: _____

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"/> Diabetes
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Skin Rashes
<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	

Do you have a history of stroke or hypertension? _____

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 any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

NAME _____

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 _____

FAMILY HISTORY:

Parents:
Father: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if deceased: _____ (check one)
Mother: living ___ deceased ___ Current age if still living: ___ Cause of death and age at death if deceased: _____ (check one)

Check if applicable to you: ___ As an adopted child, little is known of birth parents or family.

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 Father, Mother, Sister, Brother):

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

Financial Responsibility:

Major Medical ___ Workers Compensation ___ Auto Accident ___ Medicare ___ Other ___
Insurance Plan Name or Program Name: _____
Insured's Name (as it appears on the insurance card): _____
Insured's Address (if same as patient put "same"): _____
City _____ State _____ Zip _____ Tel # _____
Employer's Name or School Name: _____
Insured's Date of Birth: _____ Male ___ Female ___
Is there another health benefit plan? Yes ___ No ___
Insurance Plan Name or Program Name: _____
Guarantor (if applicable): _____ Relationship to Patient _____
Guarantor's Address (if same as patient put "same"): _____
City _____ State _____ Zip _____ Tel # _____

- 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.
- Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

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: _____

NAME _____

SUMMARY

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. 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 _____
6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
7. 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? _____
8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain _____
11. Remarks: _____

NO SYMPTOMS

EXTREME SYMPTOMS

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

Pain Drawing

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>

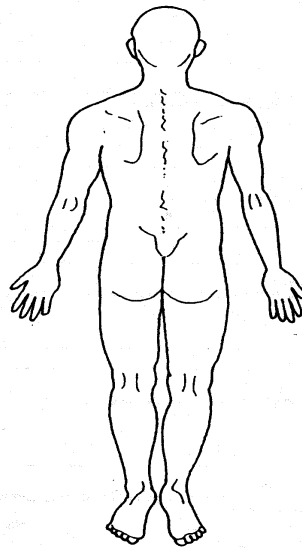
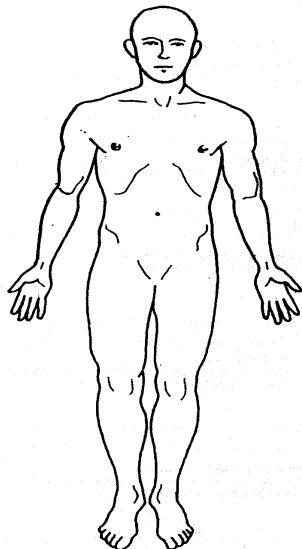
Numbness =====

Pins & Needles o o o o

Burning x x x x

Stabbing // // // //

Throbbing ~ ~ ~ ~ ~



Doctor's Signature _____ Date _____