Chiropractic Case History/Patient Information

Date:__________________ Patient #___________ **Doctor: Debbie Moore, DC**

Name:__________________________ Social Security #__________________Home Phone: _______________

Address:___________________________________City:___________________ State:______ Zip:___________

E-mail address:____________________________Fax # __________________ Cell Phone:__________________

Age:_______ Birth Date:___________ Race:______ Marital: Married Single Widowed Divorced

Occupation:_________________________ Employer:____

Employer's Address:__________________________________ Office Phone:______________________________

Spouse:___________________ Occupation:________________ Employer:_______________________________

How many children?____________Names and Ages of Children:____

____

Name of Nearest Relative:________________________ Address:______________________Phone:___________

How were you referred to our office?____

Family Medical Doctor:____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this 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:_________________________

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (check the conditions that apply to you)

___Broken/Fractured Bones
___Circulatory Problems
___Rheumatoid Arthritis
___Osteoarthritis
___Seizures/Convulsions
___Excessive Bleeding
___High Blood Pressure
___Headaches
___Neck Pain
___Stiff Neck
___Sleeping Problems
___Back Pain
___Nervousness
___Tension
___Irritability
___Chest Pains/Tightness
___Dizziness

___Low Blood Pressure
___Congenital Disease
___Epilepsy
___Pace Maker
___Strokes
___Cancer
___Ruptures
___Shoulder/Neck/Arm Pain
___Numbness in Fingers
___Numbness in Toes
___Difficulty Urinating
___Weakness in Extremities
___Breathing Problems
___Fatigue
___Lights Bother yes
___Ears Ringing
___Loss of Balance

___Eating Disorder
___Alcoholism
___Drug Addiction
___HIV Positive
___Gall Bladder
___Depression
___Ulcers
___Fainting
___Loss of Smell
___Loss of Taste
___Unusual Bowel Patterns
___Cold Feet
___Cold Hands
___Muscle Spasms
___Frequent Colds
___Fever
___Sinus Problems

___Coughing up blood
___Measles
___Mumps
___Chicken Pox
___Childhood Diseases
____
____
___Diabetes
___Indigestion Problems
___Joint Pain/Swelling
___Menstrual Difficulties
___Weight Loss/Gain
___Depression
___Loss of Memory
___Buzzing in Ears
___Women: Are you currently pregnant?

Have you had any:

Major illnesses ☐ No ☐ Yes Describe ____

Hospitalizations or Surgeries ☐ No ☐ Yes Describe ____

Injuries ☐ No ☐ Yes Describe ____

Falls ☐ No ☐ Yes Describe ____

Auto accidents ☐ No ☐ Yes Describe and Date ____

Women, Number or Births________ and delivery method (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 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?___ 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 take drugs? ________ 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_______
What is your typical stress level?________________________________

FAMILY HISTORY:

Parents:
Father: living___ deceased____ Current age if still living:______ Cause of death and age at death if deceased:____________________

Mother: living___ deceased____ Current age if still living:______ Cause of death and age at death if deceased:____________________

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 **F**ather, **M**other, **S**ister, **B**rother):

___Tuberculosis
___Diabetes
___Stroke
___Arthritis
___Cancer
___Asthma
___Hay Fever
___Kidney Disaese
___Liver Disease
___Mental Illness
___Heart Disease
___Lung Disease
___Back Trouble
___Bursitis
___Constipation
___Disc Problem
___Emphysema
___Epilepsy
___Headaches
___High Blood Pressure
___Insomnia
___Migraine
___Nervousness
___Neuritis
___Neuralgia
___Pinched Nerve
___Scoliosis
___Sinus Trouble
___Stomach Trouble
___Other ________________

INFORMED CONSENT TO TREAT: I understand and am informed that, in the practice of chiropractic medicine there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that I may revoke this consent at anytime verbally or in writing to the doctor. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures outlined by my doctor of chiropractic in my treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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:________________