Back In Balance Chiropractic Clinic

Chiropractic Case History / Patient Information

Date: ____________ **File #** ____________

Name: ________________________ Social Security #_________________Home Phone: ______________

Address: __________________________________City:__________________ State: _____ Zip: ___________

E-mail address ___________________________Fax # _________________ Cell Phone: ___________________

Age: _______ Birth Date: ___________ Race: ______ Marital: M S W D

Occupation: ________________________ Employer: ________________________ Phone: _______________

Employer's Address: _________________________ City: _________________ State: ____ Zip: ________________

Spouse: __________________ Occupation: _______________ Employer: ________________ City:_________

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? Yes No Address: _________________ City: _______________ State: ____ Zip: __________

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? (Place a check mark by conditions that apply to you)

_____Broken or Fractured Bones	_____Osteoarthritis	_____Eating Disorder
_____Circulatory Problems	_____Epilepsy	_____Alcoholism
_____Rheumatoid Arthritis	_____Pace Maker	_____Drug Addiction
_____Seizures/Convulsions	_____Strokes	_____HIV Positive
_____A Congenital Disease	_____Cancer	_____Gall Bladder
_____Excessive Bleeding	_____Ruptures	_____Depression
_____High/Low Blood Pressure	_____Coughing Blood	_____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/ drugs/ supplements 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: ____
____

SOCIAL HISTORY:

Do you drink alcoholic be*verag*es? ___ 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:_____________________________________
Do you exercise? __________ If yes, what is the frequency and type of exercise?________________________
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 are your hobbies?

FAMILY HISTORY:

Father: Living___ Deceased____ Current age if still living:______ Cause of death and age:___________________

Mother: Living___ Deceased____ Current age if still living:______ Cause of death and age: __________________

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 place a F,M , S,B to whom it applies to; **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 ____

Please check any and all insurance coverage that may be applicable in this case**:**
___ Major Medical ___ Worker's Compensation ___ Medicaid ___ Medicare ___ Auto Accident
___ Medical Savings Account & Flex Plans ___ Other ____

Name of Primary Insurance Company:____
Name of Secondary Insurance Company (if any):____

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:______________