Chiropractic Case History / Patient Information

Date: ____________ Dr. ___________________________________

Name:____ Gender: M F Birth Date:__________________

Social Security #____________________________ Marital Status: M S W D Age:_________ Race:_____________

Phone: ______________________________ E-mail Address:____

Address:_____________________________________City:___________________ State:______ Zip:____________

Occupation:___________________________ Employer:_____________________ Work Phone: ___________________

Emergency Contact: _____________________ Relationship: ____________________ Phone: ___________________

Spouse:____________________________________ Occupation:____

How were you referred to our office?______________________________ Family Medical Doctor:___________________

May we update your medical doctor regarding your care at this office? Yes ☐ No ☐

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

Name of Primary Insurance Company: ____
Name of Secondary Insurance Company (if any): ____
I will not be filing Insurance ☐

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 rendered 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.

The following person(s) have my permission to receive my personal health information:

*Name:*____ *Relationship:* ______________________________

*Name:*____ *Relationship:* ______________________________

Patient's Signature:____ Date:______________________

Signature of Parent or Guardian:____ Date:______________________

COMPLAINTS

List any discomforts, complaints or other symptoms you have been experiencing ________________________________

____

Do you have a history of stroke or hypertension?____

What medications or drugs are you taking?____

If yes, describe:____

Do you have any Congenital Conditions? Ye☐ N☐

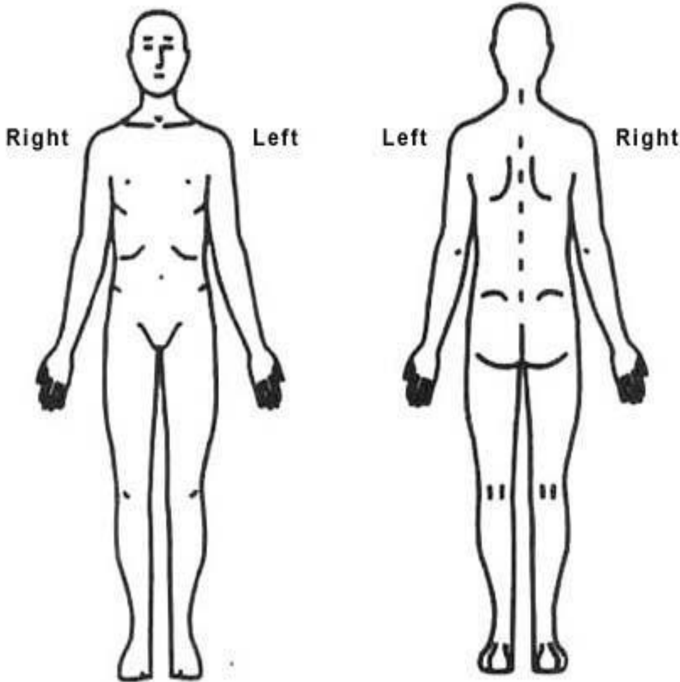
If Yes, Describe ____

Women: Are you pregnant? Yes☐ No☐

What makes the pain better? ☐ Acupuncture ☐ Chiropractic Treatment ☐ Heat ☐ Ice ☐ Massage
☐ Nothing works ☐ Pain Medicine ☐ Physical Therapy ☐ Sleep/Rest ☐ Stretching

Place an "X" on all areas of pain on the diagram below.

LARGER "X" for more major problems.
Smaller "x" minor problems.



Describe Intensity of symptoms
List region of pain and circle severity number (1=least, 10=greatest)
Rate the intensity of your pain
Minimum, mild, moderate, severe, unbearable, none
Describe Nature of symptoms
Burning, dull, numb, radiating, sharp, shooting, stabbing, tight, tingling, throbbing, other
Describe frequency of symptoms
Constant, frequent, occasional, intermittent
(Example: Neck_____severe, sharp, constant ________)
least 1 2 3 4 5 6 7 8 9 10 greatest

Neck/Head ____
1 2 3 4 5 6 7 8 9 10

Upper Back ____
1 2 3 4 5 6 7 8 9 10

Mid Back/ Ribs ____
1 2 3 4 5 6 7 8 9 10

Low Back ____
1 2 3 4 5 6 7 8 9 10

Hips ____
1 2 3 4 5 6 7 8 9 10

Arms/ shoulders/ elbows/ wrist/ hands__________________________
1 2 3 4 5 6 7 8 9 10

Legs/ knees/ ankles/ feet ______________________________
1 2 3 4 5 6 7 8 9 10

ACCIDENT INFORMATION

Immediate below portion only

Is this condition the result of an accident? Yes☐ No☐ If yes, date of accident ___________________________

Type of accident? Circle one: Automobile Accident Work Comp Personal Injury Other____________________

Have you ever had chiropractic care? Yes☐ NO☐ if yes, where?______________________________________

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= O SOMETIMES= S NEVER= N

__________ Vigorous Exercise
__________ Moderate Exercise
__________ Alcohol Use
__________ Drug Use
__________ Tobacco Use
__________ Caffeine
__________ High Stress Activity

_________ Family Pressures
_________ Financial Pressures
_________ Other Mental Stresses
_________ Other (specify)________________________
____
____

Have you had or do you now have any of the following symptoms/conditions?
Please indicate with the letter "**N**" if you have these conditions **now** or "**P**" if you have had these conditions **previously**.

N = Now P = Previously

Condition		Condition	
Chest Pains/Tightness	________	HIV Positive	________
Difficulty Urinating	________	Loss of Balance	________
Dizziness	________	Feet Cold	________
Ears Ring	________	Osteoporosis	________
High Blood Pressure	________	Fever	________
Pacemaker	________	Loss of Taste	________
Rheumatoid Arthritis	________	Loss of Smell	________
Stroke	________	Cancer	________
Menstrual Difficulties	________	Numbness in the genital region	________

Have you ever broken any bones? Yes ☐ No ☐

If yes, explain____

Have you ever had surgery? Yes ☐ No ☐

If yes, explain ____

INFORMED CONSENT

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

______________________________ ______________________________

Date Printed Name

Signature of Patient

____

Signature of Parent or Guardian

____

Permission to Use Photograph/Name

I grant to Wilbeck Chiropractic, its representatives and employees the right to use photographs of me. I authorize Wilbeck Chiropractic, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Wilbeck Chiropractic may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I have read and understand the above.

Date __________________

Printed Name ____

Signature ____

Parent or Guardian Signature ____

Address ____