Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

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:_____

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? (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 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:_____
_____

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 **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:_____

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.

Doctor’s Signature _____ Date _____

Insurance Questionnaire

The following questions are necessary so that we may properly file your insurance for you. These questions are taken directly from the insurance form that we must fill out and file for you. Please answer as fully as possible.

1. Type of insurance: Medicare____Medicaid____Champus___CampVA____
   Group Health Plan____ Other____Insured's ID Number_____
2. Patient Name:_____
3. Insured's Name (as it appears on the insurance card):_____
4. Patient's Address:_____
   City_____State_____ Zip_____Tel #_____
5. Insured's Address (if same as patient put "same"):_____
   City_____State_____ Zip_____Tel #_____
6. Patient Status (circle one): Single Married Other Employed Full-time Student Part-time Student
7. Other Insured's Name (if applicable):_____
   Other Insured's Policy or Group Number:_____
   Other Insured's Date of Birth:_____ Male_____Female_____
   Employer's Name or School Name:_____
   Insurance Plan Name or Program Name:_____
8. Is the condition we are treating related to current or previous employment? Yes____ No____
9. Is the condition we are treating related to an auto accident? Yes____ No____
10. Is the condition we are treating related to another type of accident? Yes ____ No____
11. Insured's Policy Group or FECA Number:_____
    Insured's Date of Birth:_____Male_____Female_____
    Employer Name or School Name:_____
    Insurance Plan Name or Program Name:_____
12. Is there another health benefit plan? Yes____ No____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: _____Date:_____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____Date:_____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients.

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___Name of Company_____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___

Insurance Company_____Phone # _____

Claims Address_____Fax #_____

Name and title of person giving information:_____

HCFA 1500 form okay? Yes No

What is your deductible? $_____Deductible remaining? $_____

Is deductible: annual or per incident? (circle one) Date deductible starts:_____

Percentage payment:_____%

Is there a maximum number of visits allowed? Yes No If yes, number:_____

Will you pay for therapy? Yes No Maximum # per visit_____ per year?_____

Any $ limitations on visits?_____ Therapy?_____

Will you accept E/M codes (99201-99204) from chiropractors?_____

Will you accept CMT (Chiropractic Manipulative codes 98940-98943)?_____

Any x-ray limitations?_____

Do you require pretreatment authorization? Yes No

Procedure:_____

Do you pay for examinations? Yes No

Any re-exam stipulations?_____

Do you pay for: Supports Pillows Vitamins/Supplements Orthotics

Any limitations?_____

Do you accept and honor assignment of benefits? Yes No

Add'l Notes:_____

_____

Person taking information:_____Date:_____

Office Use Only
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□ 4-5
□ >5

Patient #:_____

Pain Drawing

Name:_____ Date:_____

Date of Birth:_____ Examiner:_____

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 start 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 ~ ~ ~ ~ ~ ~