40 Brookwood Avenue, Carlisle, PA 17015 ** (717) 609-1333

# Case History/Patient Information

Date:_________________ Name:_____________________________________ Nickname:__________________

Address:____________________________________City:___________________ State:______ Zip:__________

Home Phone:_______________ Cell Phone:_______________ E-mail address:__________________________

Would you like appointment reminders? Y N If yes, how would you like to receive them? Call Text Email

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

Social Security #__________________ License # : _______________

Occupation:_________________________ Employer:________________________________________________

Employer's Address:________________________________________________ Office Phone: _______________

Spouse:___________________ Occupation:________________ Employer:________________________________

How many children?____________ Names of Children:_______________________________________________

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?___________

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 Insured: _________________________________ Birth Date: _________________________________

Name of Secondary Insurance Company (if any):_____________________________________________________

Name of Insured: _________________________________ Birth Date: _________________________________

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

Name:_________________________________ Relationship:_________________________________

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.**

Patient's Signature:_____________________________________________________ Date:________________

Guardian's Signature Authorizing Care:_____________________________________ Date:________________

PATIENT NAME ____________________________________________DATE ____________________

# HISTORY OF PRESENT AND PAST 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:_________________________

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:_______________________________________________________________________________

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe ______________________________

Women: Are you pregnant?___________________

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

| | | | | | |
|---|---|---|---|---|---|
| Headaches___ Frequency | _______ | Loss of Balance | _______ | Rheumatoid Arthritis | _______ |
| Neck Pain | _______ | Fainting | _______ | Excessive Bleeding | _______ |
| Stiff Neck | _______ | Loss of Smell | _______ | Osteoarthritis | _______ |
| Sleeping Problems | _______ | Loss of Taste | _______ | Pacemaker | _______ |
| Back Pain | _______ | Unusual Bowel Patterns | _______ | Stroke | _______ |
| Nervousness | _______ | Feet Cold | _______ | Ruptures | _______ |
| Tension | _______ | Hands Cold | _______ | Eating Disorder | _______ |
| Irritability | _______ | Arthritis | _______ | Drug Addiction | _______ |
| Chest Pains/Tightness | _______ | Muscle Spasms | _______ | Gall Bladder Problems | _______ |
| Dizziness | _______ | Frequent Colds | _______ | Seizures/Epilepsy | _______ |
| Shoulder/Arm Pain | _______ | Fever | _______ | Low Blood Pressure | _______ |
| Numbness in Fingers | _______ | Sinus Problems | _______ | Osteoporosis | _______ |
| Numbness in Toes | _______ | Diabetes | _______ | Heart Disease | _______ |
| High Blood Pressure | _______ | Indigestion Problems | _______ | Cancer | _______ |
| Difficulty Urinating | _______ | Joint Pain/Swelling | _______ | Coughing Blood | _______ |
| Weakness in Extremities | _______ | Menstrual Difficulties | _______ | Alcoholism | _______ |
| Breathing Problems | _______ | Weight Loss/Gain | _______ | HIV Positive | _______ |
| Fatigue | _______ | Depression | _______ | Ulcers | _______ |
| Lights Bother Eyes | _______ | Loss of Memory | _______ | | |
| Ears Ring | _______ | Buzzing in Ears | _______ | | |
| Broken Bones/Fractures | _______ | Circulation Problems | _______ | | |

PATIENT NAME ____________________________________________DATE ____________________

# FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

| CONDITION | FATHER Age [ ] | MOTHER Age [ ] | SPOUSE Age [ ] | BROTHER(S) Age [ ] Age [ ] | SISTERS Age [ ] Age [ ] | CHILDREN Age [ ] Age [ ] |
|---|---|---|---|---|---|---|
| Arthritis | | | | | | |
| Asthma-Hay Fever | | | | | | |
| Back Trouble | | | | | | |
| Bursitis | | | | | | |
| Cancer | | | | | | |
| Constipation | | | | | | |
| Diabetes | | | | | | |
| Disc Problem | | | | | | |
| Emphysema | | | | | | |
| Epilepsy | | | | | | |
| Headaches | | | | | | |
| Heart Trouble | | | | | | |
| High Blood Pressure | | | | | | |
| Insomnia | | | | | | |
| Kidney Trouble | | | | | | |
| Liver Trouble | | | | | | |
| Migraine | | | | | | |
| Nervousness | | | | | | |
| Neuritis | | | | | | |
| Neuralgia | | | | | | |
| Pinched Nerve | | | | | | |
| Scoliosis | | | | | | |
| Sinus Trouble | | | | | | |
| Stomach Trouble | | | | | | |
| Other: | | | | | | |
| | | | | | | |

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient ____________________________________________________________

Signature of Patient/Legal Guardian ______________________________________________

Date __________________________________________________