Crouchley Chiropractic Center - Patient Case History/Patient Information

Date: _____________ Patient #: ___________

Name: ________________________ Address: _______________________ City: ___________________
State: ______ Zip: _________ Age: ____ Birth Date: ___________ Social Security #: ____________
Home Phone: _________________ Cell Phone: _________________ Work Phone: _________________
Marital Status: M S D W How many children?: _____ Occupation: _______________________
Employer: ______________________ Employer's Address: ______________________________________
Spouse: ________________ Occupation: _________________ Employer: _________________________
Nearest relative-- Name: ____________________________ Phone: ____________________________
Address: ____
How were you referred to our office?: ____
Family Medical Doctor: ____
Purpose of this appointment: ____
Days lost from work: ___________ Date of last physical examination: ____________________________
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?: ____

Please circle 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. I understand that interest is charged on overdue accounts at the annual rate of 18%.

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: ______________

What is your major symptom?: ____

Date symptoms appeared or accident happened: ____________________________________

If your condition is accident related, is it due to: **Auto** **Work** **Other**: ____________________

____

Have you ever had the same or a similar condition?: **Yes** **No**

If yes, when and describe: ____

____

How did your condition originally occur?: ______________________________________

Has it become worse recently?: **Yes** **No** **Same** **Better** **Gradually Worse**

If yes, when and how?: ____

How frequent is the condition?: **Constant** (100%-75%) **Frequent** (75%-50%) **Intermittent** (50%-25%) **Occasional** (25%-1%)

How long does it last?: **All Day** **Few Hours** **Minutes**

Have you been treated for this condition by another physician, chiropractor or therapist?: **Yes** **No**

If yes, please describe the treatment: ____

____

Describe the pain (circle all that apply): **Sharp** **Dull** **Aching** **Burning** **Numbing** **Shooting** **Tightness** **Throbbing** **Diffuse** **Tingling** **Other:________**

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?: ______________________________

What makes the problem worse? (circle all that apply): **Standing** **Sitting** **Lying** **Bending** **Lifting** **Twisting** **Other:____________________**

Have you had any broken bones?: **Yes** **No**

If yes, please list and give dates: ____

Do you have any allergies to any medications?: **Yes** **No**

If yes, describe: ____

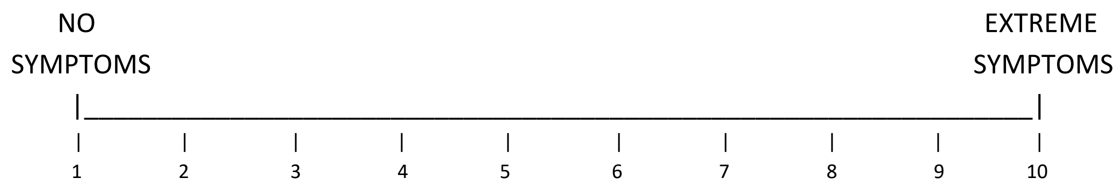
Do you have any allergies of any kind?: **Yes** **No**

If yes, describe: ____

Do you have a history of stroke or hypertension?: ____________________________________

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?: **Yes** **No** **Uncertain**

Please place an "X" on the line below to indicate your level of discomfort.
The scale is from 1 to 10 with 10 being the most extreme symptoms.



Doctor's Signature: ______________________________________ Date: ______________