

## Chiropractic Case History/Patient Information

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
 Gender:  Female  Male Race: \_\_\_\_\_ Marital Status:  Married  Single  Other: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
 Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 How many children? \_\_\_\_\_ Ages of Children: \_\_\_\_\_  
 Emergency Contact (relationship?): \_\_\_\_\_ Phone: \_\_\_\_\_  
 How were you referred to our office? \_\_\_\_\_ Family Medical Doctor: \_\_\_\_\_

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. [The following person\(s\) have my permission to receive my personal health information:](#)

List persons here: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### History of Present and Past Illness

Reason(s) for visit: \_\_\_\_\_ Date symptoms appeared: \_\_\_\_\_  
 Is this due to: Auto  Work  Other \_\_\_\_\_ Have you ever had a similar condition?  No  Yes  
 Date of last physical examination: \_\_\_\_\_ Days lost from work: \_\_\_\_\_  
 Do you have a history of stroke or high blood pressure?  No  Yes  
 Have you had any major illnesses?  Cancer  Diabetes  Heart Disease  Other: \_\_\_\_\_  
 Have you had any surgeries?  No  Yes, describe: \_\_\_\_\_  
 Have you been hospitalized?  No  Yes, describe: \_\_\_\_\_  
 Have you had any major injuries or falls?  No  Yes, describe: \_\_\_\_\_  
 Have you been in any auto accidents?  No  Yes, when? \_\_\_\_\_  
 Have you been treated for any health condition by a physician in the last year?  No  Yes  
 If yes, describe: \_\_\_\_\_  
 What medications or nutritional supplements are you taking? \_\_\_\_\_  
 \_\_\_\_\_  
 Have you used corticosteroids (Cortisone, Prednisone, etc.)?  No  Yes, describe: \_\_\_\_\_  
 Do you have allergies of any kind?  No  Yes  
 If yes, describe: \_\_\_\_\_  
 Do you have any Congenital Condition?  No  Yes, please describe: \_\_\_\_\_  
 Women: Are you pregnant?  No  Yes  
 Please give information about any childbirths with dates: \_\_\_\_\_

## SOCIAL HISTORY

**What type of regular exercise do you perform?** \_\_\_ Light \_\_\_ Moderate \_\_\_ Vigorous \_\_\_ None  
**Are you on a special diet?** \_\_\_ No \_\_\_ Yes, describe: \_\_\_\_\_ **How many cups of water do you drink per day?** \_\_\_\_\_  
**Do you drink caffeinated beverages?** \_\_\_ No \_\_\_ Yes, drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_ per month? \_\_\_\_\_  
**Do you drink alcohol?** \_\_\_ No \_\_\_ Yes, drinks per day? \_\_\_\_\_ per week? \_\_\_\_\_ per month? \_\_\_\_\_  
**Do you use any recreational drugs?** \_\_\_ No \_\_\_ Yes  
**Do you use tobacco of any kind?** \_\_\_ Never \_\_\_ In the past \_\_\_ Current user (\_\_\_ often or \_\_\_ sometimes)  
**How many hours of sleep are you getting per night?** \_\_\_ less than 5 \_\_\_ 6-8 \_\_\_ 8-10 \_\_\_ 10 or more  
**How would you rate your sleep?** \_\_\_ wake fully rested \_\_\_ wake moderately rested \_\_\_ wake poorly rested  
**How would you rate your stress level (please circle)?** No Stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressed  
**List your major stressors:** \_\_\_\_\_ **What are your health goals?** \_\_\_\_\_

## Family History

Please indicate if an immediate family member has had any of the following: ***(list family member(s) and describe)***

**Cancer:** \_\_\_\_\_ **Heart Problems:** \_\_\_\_\_

**Diabetes:** \_\_\_\_\_ **Other:** \_\_\_\_\_

## Review of Systems

Please indicate if you have any of the following with:

<b>Constitutional</b>	___ none ___ chills ___ daytime drowsiness ___ fatigue ___ fever ___ loss of appetite ___ night sweats ___ weight gain / loss ___ fainting excessive thirst headaches frequent urination other: _____
<b>Eyes, Vision</b>	___ none ___ blind spots ___ cataracts ___ double vision ___ wears contacts / glasses itching tearing other: _____
<b>Ears, Nose, Throat</b>	___ none ___ nosebleeds ___ ear discharge ___ loss of smell ___ dizziness ___ runny nose ___ hearing loss ___ nasal congestion ___ headaches ___ sinus pain ___ ear pain ___ history of head injury sore throat loss of taste other: _____
<b>Respiratory</b>	___ none ___ sputum production ___ asthma ___ shortness of breath cough coughing up blood wheezing other: _____
<b>Cardiovascular</b>	___ none ___ high blood pressure ___ heart attack ___ stroke ___ Pacemaker ___ low blood pressure ___ circulation issues ___ heart disease heart murmur chest pains/tightness palpitations other: _____
<b>Gastrointestinal</b>	___ none ___ diarrhea ___ constipation ___ abdomen pain ___ loss of appetite ___ ulcers ___ jaundice ___ indigestion ___ abnormal stool ___ difficulty swallowing ___ belching ___ heartburn ___ hemorrhoids ___ rectal bleeding ___ gallbladder issues liver issues other: _____
<b>Female</b>	___ none ___ on birth control ___ menstrual difficulties ___ kidney or bladder issues hormone therapy menopause other: _____
<b>Male</b>	___ none ___ kidney issues ___ bladder issues prostate problems other: _____
<b>Skin</b>	___ none ___ itching ___ lesions/ulcers ___ numbness ___ rash ___ shingles hives bruises skin disorder hair loss other: _____
<b>Neurologic</b>	___ none ___ numbness ___ memory loss ___ stroke ___ dizziness ___ weakness ___ balance loss ___ fainting headache seizures sleep disturbance other: _____
<b>Psychologic</b>	___ none ___ confusion ___ loss of appetite ___ memory loss ___ anxiety ___ insomnia ___ mood change ___ eating disorder stress ___ depression ___ nervousness other: _____
<b>Hematologic</b>	___ none ___ bleeding ___ blood clotting ___ blood transfusion ___ anemia fatigue bruise easily lymph node swelling other: _____
<b>Musculoskeletal</b>	___ none ___ arthritis ___ Rheumatoid arthritis ___ joint pain/swelling osteoporosis (weak bones) other: _____
<b>Endocrine</b>	___ none ___ Cushing's disease ___ diabetes ___ excessive thirst ___ constantly hot or cold ___ heat or cold intolerant ___ hyperparathyroidism ___ hyperthyroidism ___ hypothyroidism ___ increased foot or hand size ___ increased urination ___ pancreatic conditions ___ polydipsia ___ polyuria ___ purple striae ___ steroid treatments ___ testosterone deficiency ___ thyroid problems

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

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**INFORMED CONSENT TO CHIROPRACTIC TREATMENT**

\_\_\_\_\_ **(INITIAL)** I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays, on me, by anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by a licensed Physician of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with the office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of all healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its consent, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

**HIPAA CONSENT**

\_\_\_\_\_ **(INITIAL)** The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA (a copy is located in waiting room) and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The initial does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

**X-RAY CONSENT**

\_\_\_\_\_ **(INITIAL)** I hereby acknowledge Wirth Chiropractic has informed me of the advisability of, risk, inherent in, and the probable consequences of X-rays. They have explained to me the reasons and need for such x-rays. With my understanding I am giving Wirth Chiropractic my consent to take X-rays.

**I certify the information above is correct:**

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

If patient is a minor or under a guardianship order as defined by State law:

**Patient Name:** \_\_\_\_\_ **By:** \_\_\_\_\_  
Signature of Parent/Guardian (circle one)