

# 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 How many children? \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Office Phone \_\_\_\_\_  
Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Name of Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
How were you referred to our office? \_\_\_\_\_  
Family Medical Doctor \_\_\_\_\_  
Purpose of this appointment \_\_\_\_\_

Date symptoms appeared or accident happened \_\_\_\_\_  
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 \_\_\_\_\_ What surgeries have you had? (Include dates) \_\_\_\_\_  
\_\_\_\_\_

Serious illnesses (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 check any and all insurance coverage that may be applicable in this case.  
Major Medical      Worker's Compensation      Medicaid  
Medicare      Auto Accident      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 understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. 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 16%.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_