



**HIPAA
PROTECTED HEALTH INFORMATION
AUTHORIZED ACCESS ONLY**

Today's Date:
Case #:
Patient/Clinic ID #:

PATIENT CASE HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name:		DOB:	
Driver's License #:		SSN #:	
Address:			
City:		State:	Zip:
Home Phone #:		Cell Phone #:	Email:
Insurance Co :		Effective Date of Coverage:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Occupation:		Shift 1 2 3	Description:
Employer:		Work Phone #:	Ext.
Work Address:		Years Worked:	
Spouse:		List Children:	
Spouse SSN#:		Spouse's Occupation:	
Spouse's Employer:		Spouse's Work #:	Ext.
Spouse's Insurance:		Spouse's Ins. Phone #:	
Last Doctor's Name:		List Medication:	
Care Received:		List Surgeries:	
Results:			

Are your present problems due to an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> On the job <input type="checkbox"/> Auto Collision <input type="checkbox"/> Personal Injury <input type="checkbox"/> Other
Have you made a report of your accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To Employer <input type="checkbox"/> Auto Carrier <input type="checkbox"/> Other _____
Has the accident been reported? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Auto Carrier <input type="checkbox"/> Other _____
Are you now or have you been disabled/impaired? (Service or work) <input type="checkbox"/> Yes <input type="checkbox"/> No When _____
Have you retained an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No Name & Address _____

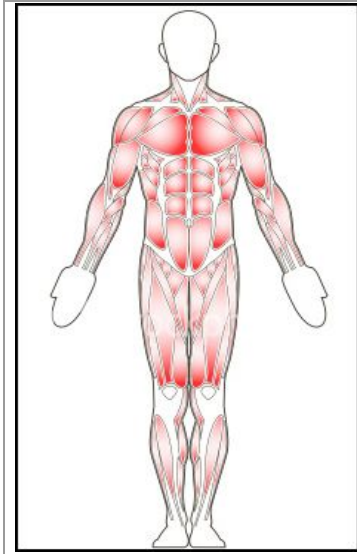
Have you had any of the following diseases?		
<input type="checkbox"/> 303.9 Alcoholism	<input type="checkbox"/> 345. Epilepsy	<input type="checkbox"/> 072. Mumps
<input type="checkbox"/> 280. Anemia	<input type="checkbox"/> 240. Goiter	<input type="checkbox"/> 511. Pleurisy
<input type="checkbox"/> 541. Appendicitis	<input type="checkbox"/> 429.9 Heart Disease	<input type="checkbox"/> 480. Pneumonia
<input type="checkbox"/> 716. Arthritis	<input type="checkbox"/> 042. HIV Positive	<input type="checkbox"/> 045. Polio
<input type="checkbox"/> 239. Cancer	<input type="checkbox"/> 487. Influenza	<input type="checkbox"/> 390. Rheumatic Fever
<input type="checkbox"/> 052. Chicken Pox	<input type="checkbox"/> 724.2 Low Back Pain	<input type="checkbox"/> 737.30 Scoliosis
<input type="checkbox"/> 250. Diabetes	<input type="checkbox"/> 055. Measles	<input type="checkbox"/> 846. Sprain/Strain Sacroiliac

690. Eczema

319. Mental Disorder

847.0 Whiplash

CHIEF COMPLAINT / REGION OF PAIN	HABITS	EXERCISE
1) _____	<input type="checkbox"/> Smoking Packs/day _____	<input type="checkbox"/> None
2) _____	<input type="checkbox"/> Alcohol Cups/day _____	<input type="checkbox"/> Moderate
3) _____	<input type="checkbox"/> Coffee Cups/day _____	<input type="checkbox"/> Daily
4) _____	<input type="checkbox"/> Soda Cups/day _____	Type _____



SEVERITY OF PAIN
List region of pain and circle severity number. (1 = least, 10 = greatest)

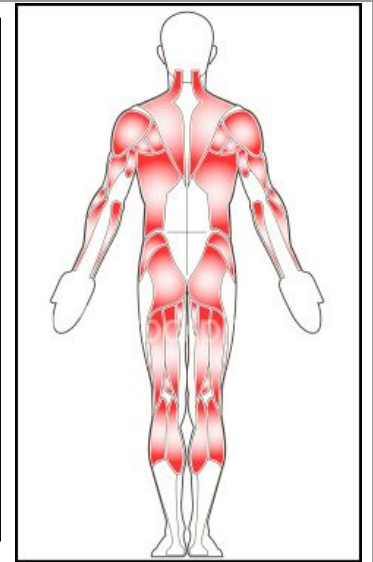
MARK PAIN REGION
Burning – Stabbing Sharp – Constant

Mark Pain Area
+++ Burning
000 Stabbing
--- Sharp
!!! Constant
xxx Other

Regions

Neck	1	2	3	4	5	6	7	8	9	10
Mid Back	1	2	3	4	5	6	7	8	9	10
Lower Back	1	2	3	4	5	6	7	8	9	10
Hips	1	2	3	4	5	6	7	8	9	10
Arms	1	2	3	4	5	6	7	8	9	10
Legs	1	2	3	4	5	6	7	8	9	10

Please mark the area of pain on the drawing using the code listed above.



FAMILY HISTORY						
Mother - Living: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Kidney	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back	
Father - Living: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Kidney	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back	
Brother(s) - Living: # of	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Kidney	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back	
Sister(s) - Living: # of	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Kidney	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back	
Adoption History	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Kidney	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back	
Mother Living: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Kidney	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back	

OFFICE USE ONLY	
Patient's Last Physical:	Patient's Last Spinal Exam:
Patient's Last Lab:	Patient's Last Spinal X-ray:
Patient's X-ray:	Patient's Last EMG:
Patient's Prostate Exam:	Patient's Last Infrared Thermography:
Patient's Last Pap Smear:	Patient's Last Disc Exam:
Patient's Last Breast Exam:	Patient's Last MRI: CT Scan:
Notes:	

Please enter: "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable.
A complete history and understanding of your health will facilitate care.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR/NOSE/THROAT	RESPIRATORY
___ 784.0 Headache	___ 783. Poor Appetite	___ 368.9 Poor Vision	___ 786.2 Chronic Cough
___ 780.6 Fever	___ 536.8 Poor Digestion	___ 378.0 Crossed Eyes	___ 786.3 Spitting Blood
___ 780.99 Chills	___ 994.2 Starvation	___ 379.91 Pain in Eyes	___ 786.4 Spitting Phlegm
___ 780.8 Night Sweats	___ 787.3 Belching or Gas	___ 389.9 Deafness	___ 786.50 Chest Pain
___ 780.2 Fainting	___ 787.0 Nausea	___ 388.70 Earache	___ 386.09 Difficulty Breathing
___ 780.4 Dizziness	___ 787.0 Vomiting	___ 388.3 Ear Noises	
___ 780.3 Convulsions	___ 578.0 Vomiting Blood	___ 388.6 Ear Discharges	GENITO-URINARY
___ 780.52 Loss of Sleep	___ 536.8 Pain over Stomach	___ 478.1 Nasal Obstruction	___ 788.4 Frequent Urination
___ 780.7 Fatigue	___ 564.0 Constipation	___ 784.7 Nose Bleeds	___ 788.1 Painful Urination
___ 799.2 Nervousness	___ 787.91 Diarrhea	___ 462. Sore Throats	___ 599.7 Blood in Urine
___ 783. Loss of Weight	___ 562.1 Colon Trouble	___ 784.49 Hoarseness	___ 590. Kidney Infection
___ 782. Numbness or pain in arms/legs/hands	___ 455.6 Hemorrhoids (Piles)	___ 477.9 Hay Fever	___ 788.3 Bed Wetting
___ 995.3 Allergy (What)	___ 776.7 Fluid Retention	___ 493.9 Asthma	___ 788.3 Inability to control urine
___ 786.07 Wheezing	___ 873.9 Liver Trouble	___ 460. Frequent Colds	___ 601.9 Prostate Trouble
___ 729.2 Neuralgia	___ 274. Gout	___ 240.9 Enlarged Thyroid	
	___ 782.4 Jaundice	___ 463. Tonsillitis	FOR WOMEN ONLY
	___ 575.9 Gall Bladder Trouble	___ 473. Sinus Trouble	___ 625.3 Painful Periods
MUSCLES & JOINTS			___ 626.2 Excessive Flow
___ 728.9 Weakness	CARDIO-VASCULAR	SKIN OR ALLERGIES	___ 626.4 Irregular Cycle
___ 781.0 Twitches	___ 785.0 Rapid Heart	___ 680. Skin Eruptions – No	___ 627.2 Hot Flashes
___ 723.5 Stiff Neck	___ 427.89 Slow Heart	___ 698.9 Itching	___ 625.3 Cramps or Backaches
___ 724.5 Backache	___ 401.9 High Blood Pressure	___ 924.9 Bruising Easily	___ 623.5 Vaginal Discharge
___ 719.0 Swollen Joints	___ 458.9 Low Blood Pressure	___ 701.1 Dryness	___ Pregnant at this time
___ 781. Tremors	___ 786.51 Pain Over Heart	___ 680.9 Boils	___ Last Pap
___ 729.5 Foot Trouble	___ 429.9 Heart Trouble	___ 782. Sensitive Skin	By Whom _____
___ 724.79 Painful Tail Bone	___ 719.07 Swelling Ankles	___ 708.9 Hives or Allergy	Other _____
___ 724.5 Pain between Shoulder	___ 459.9 Poor Circulation	___ 692.9 Eczema	
___ 737.3 Spinal Curvature	___ 454.9 Varicose Veins	___ Medicines	
	___ 436. Strokes	_____	
	___ 454.9 Varicose Veins	_____	
	___ 785.1 Palpitations	_____	

IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES - HOSPITALIZATION

DATE	DATE	DATE	DATE
_____ Vaccinations	_____ Other	_____ Rectal Surgery	_____ Thyroid
_____ Tonsillectomy	_____ Tubes in Ears	_____ Other	_____ Stomach
_____ Gall Bladder	_____ Appendectomy	_____ Sinus	_____ Other
_____ Back Operations	_____ Female Organs	_____ Hernia	
Hospital Stays:			
Other Surgeries:			
List any accidents or falls and list dates:	<input type="checkbox"/> Car _____ <input type="checkbox"/> School _____	<input type="checkbox"/> Sports _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Recreational Vehicle _____
List any broken bones (fractures) or dislocations:			
Have you ever been on crutches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Why?	
Have you ever had a lapse of memory?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been unconscious?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had X-rays?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Why? _____ By Whom? _____	
For what ailments were these X-rays made?			
Do you suffer from any condition other than that for which you are now consulting us?			
Are you presently taking any medication – prescription or over-the-counter? <input type="checkbox"/> Yes <input type="checkbox"/> No List:			
<p>I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.</p> <p>I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. Patients may obtain copies of their file and x-rays upon request. Copying fees may apply.</p>			
Patient Signature _____		Date _____	
Guardian Signature _____		Date _____	
Doctor Signature _____		Date _____	