Life ALIGNED CHIROPRACTIC

Chiropractic Case History/Patient Information

Date:_____ Patient #_____ Doctor:_____

Name:_____ Social Security #_____

Address:_____ City:_____ State:_____Zip:_____

Phone (Cell/Home):_____ E-Mail address:_____

Birth Date:_____ Marital: ___M__S__W__D____ Race:_____

Employer:_____ Occupation:_____

Employer Address:_____ Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

How were you referred to our office?_____

Medical Doctors:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes ☐ No ☐

Insurance Information		
Name of Party Responsible for Payment?	Self ☐	Other:
Insurance Company Name:		
Address:		Phone:
Member #:	Group #:	
Effective Date:	Termination Date:	
**If an auto accident, please provide information below*		
Insurance Company/Attorney Name:		Claim #:
Contact Person:	Phone:	Fax:

AUTHORIZATION AND RELEASE: I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers. 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:

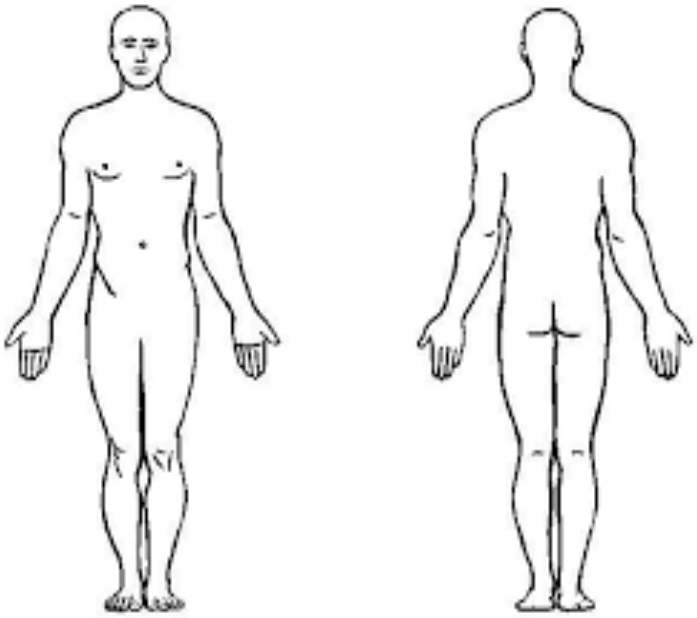
Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____Date:_____

Patient Name:

Have you ever suffered from

	YES	NO		YES	NO		YES	NO
Alcoholism			Heart Disease			Seizures/Epilepsy		
Anemia			HIV Positive			Shortness of Breath		
Arthritis			Hot Flashes			Shoulder/ Arm Pain		
Asthma			Indigestion Problems			Sciatica		
Breast Lump			Insomnia/Sleeping Problems			Sinus Problems		
Breathing Problems			Irregular Heart Beat			Scoliosis		
Broken Bones/Fractures			Irritability			Stiff Neck		
Bronchitis			Joint Pain/Swelling			Stroke		
Bruise Easily			Kidney Infection			Swelling of Ankles		
Cancer			Kidney Stones			Tension		
Chest Pains/Tightness			Leg Pain			Thyroid Condition		
Circulation Problems			Lights Bother Eyes			Tuberculosis		
Cold Extremities			Loss of Balance			Ulcers		
Constipation			Loss of Memory			Unusual Bowel Patterns		
Coughing Blood			Loss of Smell			Varicose Veins		
Depression			Loss of Taste			Venereal Disease		
Diabetes			Low Blood Pressure			Weakness in Extremities		
Difficulty Urinating			Muscle Spasms			Weight Loss/Gain		
Dizziness			Neck Pain			☐ Other:		
Drug Addiction			Nervousness					
Ears Ring			Nose Bleeds			Back Pain UPPER		
Eating Disorder			Numbness in Fingers			Back Pain MID		
Excessive Bleeding			Numbness in Toes			Back Pain LOWER		
Eye Pain or Difficulties			Osteoarthritis					
Fainting			Osteoporosis			FOR FEMALE PATIENTS		
Fatigue			Pacemaker			Menstrual Difficulties		
Fever			Polio			Excessive Menstruation		
Frequent Colds			Poor Posture			Pregnancy Loss		
Frequent Urination			Prostate Trouble			Difficult Pregnancy		
Gall Bladder Problems			Rheumatoid Arthritis			Cesarean		



Please mark on the figures where you are experiencing pain

Quality of Pain:

Dull Achy Sharp Stabbing
Tingling Numb Throbbing

Pain Scale (Circle One)

At Its Worst

Min 0 1 2 3 4 5 6 7 8 9 10 Max

Present Time

Min 0 1 2 3 4 5 6 7 8 9 10 Max

MEDICAL HISTORY

Patient Name:_____

Chief Complaint: (Purpose of today's visit)_____

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 exam:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illness, 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, please describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, please describe:_____

Do you have any Congenital Condition? ☐ Yes ☐ No If yes, please describe_____

Women: Are you pregnant? ☐ Yes ☐ No

Family History -
Family Members: Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

	YES	NO	EXPLAIN
Do you experience pain every day?			
Do your symptoms interfere with daily life?			
Does pain wake you up at night?			
Are your symptoms worse during certain times of the day?			
Do changes in weather affect your symptoms?			
Do you wear orthotics?			

Medical History Continued		
	YES	NO
Do you take vitamin supplements?		
What activities aggravate your symptoms?		

Habits	None	Moderate	Heavy		Habits	None	Moderate	Heavy
Alcohol					Coffee			
Tobacco					Drugs			
Exercise					Sleep			
Appetite					Soft Drinks			
Water					Salty Foods			
Sugary Foods					Artificial Sweeteners			

I have read and understand all of the information above and in the previous pages, and I answered each question honestly and to the best of my knowledge.

Printed Name:_____

Signature:_____Date:_____

Office Use Only