

Chiropractic Case History/Patient Information

Date: _____

Patient # _____

Doctor Kidwell

Name (Last, First, MI) _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell phone: _____

Age: _____ Birth Date _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____ Phone _____

Spouse: _____ Occupation _____ Employer: _____ Birth Date _____

How many children? _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____ City located _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto _____ Work _____ Other _____

Have you ever had the same or a similar condition? (Circle) Yes No If yes, when and describe _____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Check the conditions that apply to you)

- | | | |
|--|--|--|
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Joint Replaced |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Thyroid over / under active |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Menstrual Trouble |
| <input type="checkbox"/> Kidney Disease / Stones | <input type="checkbox"/> Gall Bladder / Stones | <input type="checkbox"/> Depression / Anxiety |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Strokes / Seizure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol Addiction |
| <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Drug Addiction |

Do you have a history of stroke or hypertension? _____

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? (Circle) Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? (Circle) Yes No

If yes, describe: _____

Do you have any allergies of any kind? (Circle) Yes No If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting _____ sitting _____ bending _____ working at a computer _____

FAMILY HISTORY:

Father: living ___ deceased ___ Current age if still living: _____ Cause of death and age at death if deceased: ___

Mother: living ___ deceased ___ Current age if still living: _____ Cause of death and age at death if deceased ___

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

_____ Tuberculosis

_____ Cancer

_____ Mental Illness

_____ Diabetes

_____ Asthma

_____ Heart Disease

_____ Stroke

_____ Kidney Disease

_____ Lung Disease

_____ Arthritis

_____ Liver Disease

_____ Other _____

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.

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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

SUMMARY

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
4. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ Few Hours ___ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
Yes ___ No ___ If yes, describe: _____
Are there other unrelated health problems? Yes ___ No ___ If yes, describe _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___
Burning ___ Stabbing ___ Other _____
7. 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? _____

8. What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___
Lifting ___ Twisting ___ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
Yes ___ No ___ Uncertain _____
11. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS

Please place an "X" on the line above to indicate level of problem.

Doctor's Signature _____ Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. Our office has the right to contact patients using information provided on the Case History form including mail, phone, or email as long as appropriate measures are taken to protect PHI.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date