**Lifetime Chiropractic Case History/Patient Information**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient #\_\_\_\_\_\_\_\_\_\_\_ Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_ Race:\_\_\_\_\_\_ Marital: M S W D

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer's Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many children?\_\_\_\_\_\_\_\_\_\_\_\_Names and Ages of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Nearest Relative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_

How were you referred to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Chiropractic Adjustment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Medical Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

Yes \_\_\_\_\_ No \_\_\_\_\_ Uncertain \_\_\_\_\_

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? 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? (Place a check mark by conditions that apply to you)

\_\_Broken or Fractured Bones \_\_Osteoarthritis \_\_Eating Disorder

\_\_Circulatory Problems \_\_Epilepsy \_\_Alcoholism

\_\_Rheumatoid Arthritis \_\_Pace Maker \_\_Drug Addiction

\_\_Seizures/Convulsions \_\_Strokes \_\_HIV Positive

\_\_A Congenital Disease \_\_Cancer \_\_Gall Bladder

\_\_Excessive Bleeding \_\_Ruptures \_\_Depression

\_\_High/Low Blood Pressure \_\_Coughing Blood \_\_Ulcers

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? Yes. No

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What medications or drugs are you taking?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies of any kind? 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:**

Parents:

Father: living\_\_\_ deceased\_\_\_\_ Current age if still living:\_\_\_\_\_\_ Cause of death and age at death if

deceased:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (check one)

Mother: living\_\_\_ deceased\_\_\_\_ Current age if still living:\_\_\_\_\_\_ Cause of death and age at death if

deceased:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (check one)

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 Father, Mother, Sister, Brother):

Tuberculosis\_\_\_\_ Cancer\_\_\_\_ Mental Illness\_\_\_\_

Diabetes \_\_\_\_ Asthma\_\_\_\_ Heart Disease \_\_\_\_

Stroke \_\_\_\_ Kidney Disease\_\_\_\_ Lung Disease\_\_\_\_

Arthritis\_\_\_\_\_ Liver Disease \_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mark the areas of the body where you feel the described sensations.**

**Use the appropriate symbol. Include ALL affected areas.**

 **NUMBNESS | | | | | | Name**

 **BURNING X X X X Date**

 **PINS & NEEDLES O O O O**

 **DULL & ACHING - - - - - - -**

 **SHARP . . . . . . .**

 **WEAK < < < < <**

 **Rate your pain, 0 no pain, 5 moderate pain, 10 intense/unbearable pain.**

 0---1---2---3---4---5---6---7---8---9---10

