Chiropractic Case History/Patient Information

Date:_____ **Doctor:_____**

Name:_____ Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Social Security #_____

Age:_____ Birth Date:_____ Race:_____ How many children?_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Name of Nearest Relative:_____ Phone:_____

How were you referred to our office?_____

Family Medical Doctor: _____

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

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	__ Prosthesis	__ Depression
__ Circulatory Problems	__ Epilepsy	__ Alcoholism	__ Osteoporosis	__ Excessive Bleeding
__ Rheumatoid Arthritis	__ Pace Maker	__ Drug Addiction	__ Coughing Blood	__ Ruptures
__ Seizures/Convulsions	__ HIV Positive	__ Fainting	__ High Blood Pressure	__ Low Blood Pressure
__ Any Congenital Disease	__ Cancer	__ Gall Bladder		

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents, hospitalizations or surgeries? (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 allergies of any kind? __ Yes __ No If yes, please list: _____

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

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

_____

FEMALE ONLY: Are you pregnant or suspect you are pregnant? ___Yes _____Due Date _____No

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SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ Yes ____No how much per week? _____

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

Do you consume caffeine? ___Yes ___No how much per day: _____

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

What are your hobbies?_____

What percentage of the day (at home or at your job) do you spend?

Lifting _____ Sitting_____ Bending_____ Working at a computer_____

FAMILY HISTORY:

Parents:

Father: ____Living ___ Deceased Current age if living: _____

Cause of death and age if deceased:_____

Mother: ___Living_ __ Deceased Current age if 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 which family member) **F**ather, **M**other, **S**ister, **B**rother

__Tuberculosis	__Diabetes	__Stroke	__Arthritis	__Cancer
__Asthma	__Kidney Disease	__Liver Disease	__Mental Illness	__Heart Disease
__Lung Disease	__High Blood Pressure	Other:_____		

Please check any and all insurance coverage that may be applicable in this case:

___ Major Medical _____Health Savings Account _____ Health Reimbursement Account

___ Worker's Compensation ___ Medicaid ___ Medicare ___ Auto Accident

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 given 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:_____

Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment - The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment - As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Patient should initial ALL procedures they are consenting to.

___ Spinal Manipulative (Adjustment) ___Muscle Strength Testing ___ Range of Motion Testing ___Electrical Muscle Stim
___ Orthopedic Testing ___ Basic Neurological ___ Vital Signs ___ Intersegmental Traction
___ Palpation ___ Postural Analysis Testing ___ Hot/Cold Therapy
___ Other (please explain) _____

The material risks inherent in chiropractic adjustment. - As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring. - Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options - Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. - Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Hammond Chiropractic* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ **Patrick Hammond DC / Ryan Nogle DC**
Print Patient's Name **Doctor's Name**

_____ _____
Signature of Patient **Doctor's Signature**
Parent /Guardian (if a minor)