Chiropractic History/Patient Information

Date:_____ Patient #_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax # _____ Cell Phone:_____

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

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?_____

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?_____

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 Dr. Curtis Legg and/or to Indiana Family Chiropractic Center. I authorize the practitioners 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 the Indiana Family Chiropractic Center 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: _____

DATE: _____

HISTORY OF PRESENT AND PAST ILLNESS:

So that we can better serve your health needs, it is required that each form be <u>completely</u> filled out prior to seeing the Doctor.

1. What is your major symptom? _____

2. Is this a reoccurrence, when was the first time you noticed the problem? _____

How did this originally occur? n _____

Has it become worse recently? Yes___ No ___ Better___ Gradually Worse ___

3. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night only ___

How long does it last? All Day _____ Few Hours _____ Minutes _____

4. Are there any other conditions or symptoms that are related to your major symptoms?

Yes ____ No ____ If yes, describe: _____

5. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____

Do you have a history of stroke or hypertension?_____

6. 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? _____

7. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____ Lifting _____

Twisting _____ Other _____

8. Have you had any broken bones, major illnesses, injuries, falls, auto accidents or surgeries?

Women, please include information about childbirth (include dates):

_____

_____

9. Have you been treated for any health condition by a physician in the last year? __Yes __ No

If yes, describe:_____

10. What medications or drugs are you taking?_____

11. Do you have any allergies of any kind (including any medications)? __Yes __ No

If yes, describe:_____

12. Do you have any Congenital Conditions? ___Yes ___ No

If yes, describe: _____

Women: Is there any chance you are you pregnant? Yes ___ No ___ Mayb e ___

Please provide any further information that may be of help in providing your treatment. This is also an opportunity to provide information on the other areas of complaint/discomfort you would like to address.

_____

_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Ulcers	_____

Other Symptoms we should know about: _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= “O” SOMETIMES= “S” NEVER= “N”

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

Please list types of exercise/physical activity: _____

Please List supplements/vitamins taken: _____

PATIENT NAME _____

DATE _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient_____

Parent/Legal Guardian _____

Date _____

Pain Drawing

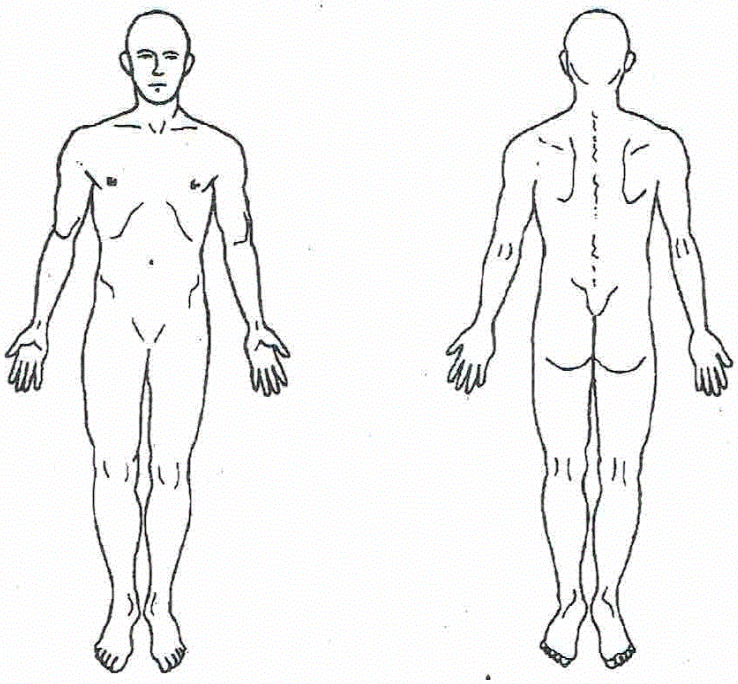
Name:_____ Date:_____

Date of Birth:_____ Examiner: _____.

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates or travels, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



Complaint #1 :_____
Complaint #2 : _____
Complaint #3 : _____

Please circle where you rate the current pain or discomfort of each complaint

1= No Pain 10 = Worst Pain Ever Experienced

Complaint #1	1	2	3	4	5	6	7	8	9	10
Complaint #2	1	2	3	4	5	6	7	8	9	10
Complaint #3	1	2	3	4	5	6	7	8	9	10