Chiropractic Case History/Patient Information

Date:_____ How did you hear about Sapulpa Chiropractic?_____

Name:_____ Social Security #: _____Home Phone #:_____
Address:_____ City:_____ State:_____ Zip:_____
E-mail address:_____ Fax #:_____ Cell Phone #:_____
Age:_____ Birth Date:_____ Race:_____ Marital Status: 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 #:_____
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 officer?_____

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 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
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Urinary Incontinence
__High/Low Blood Pressure
__Osteoarthritis
__Epilepsy
__Pace Maker
__Ulcers
__Excessive Bleeding
__Strokes
__Ruptures
__Coughing Blood
__Eating Disorder
__Alcoholism
__Lupus
__HIV Positive
__Gall Bladder
__Depression
__Diabetes
__Drug Addiction
__Cancer/Tumors (specify):_____
__Pancreatic Disease (specify):_____
__Heart Disease (specify):_____

Do you have a history of stroke or hypertension?_____

Do you smoke? No Yes If Yes, how much per day?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):_____

Are you, or do you think, you might be pregnant? [ ]Yes [ ]No

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? Women, please include birth control:_____
_____

How many days a week do you exercise? [ ]none [ ]1-2 [ ]3-4 [ ]5-7

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:_____
_____
_____

Please check any and all insurance coverage that may be applicable in this case:
[ ] Major Medical [ ] Worker's Compensation [ ] Medicaid [ ] Auto Accident
[ ] Medical Savings Account & Flex Plans [ ] Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company:_____
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 to 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:_____