120 Lowes Dr. Suite 105 • Pittsboro, NC 27312

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Case 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

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Please check any and all insurance coverage that may be applicable in this case**:**
Major Medical__ Worker's Compensation__ Medicaid__ Medicare__ Automobile__
Medical Savings Account & Flex Plans__

Name of Primary Insurance Company:_____

Subscriber/Policy # _____ Group ID:_____ Claims Address: _____

Name of Policy Holder: _____ Relationship: _____ Birthdate: _____ S.S.# _____

Address (if different from above) _____

Name of Secondary Insurance Company (if any):_____

Subscriber/Policy # _____ Group ID:_____ Claims Address: _____

Name of Policy Holder: _____ Relationship: _____ Birthdate: _____ S.S.# _____

Address (if different from above) _____

Emergency Contact:_____ Relationship: _____ Phone:_____

Family Medical Doctor:_____ Phone:_____ Date of Last Exam: _____

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

How were you referred to our office? (If internet search, be specific)_____

HISTORY OF PRESENT ILLNESS:

Purpose of Visit: _____

Is this due to: Auto___ Work____ Other_____ Days lost from work_____ Are there legal measures involved?_____

Issue # 1

Date symptoms started (Or date of accident): _____

Is this a flare-up? _____ If so, when did you originally notice a problem? _____

What makes it better?_____ Worse?_____

What have you tried to do that has not helped? _____

Please describe your condition in detail and rate your pain (if applicable) on a scale of 1 to 10 (with 10 being unbearable):_____

_____

Have you sought previous treatment for this condition? _____ Where? _____ Results: _____

Issue # 2

Date symptoms started (Or date of accident): _____

Is this a flare-up? _____ If so, when did you originally notice a problem? _____

What makes it better?_____ Worse?_____

What have you tried to do that has not helped? _____

Please describe your condition in detail and rate your pain (if applicable) on a scale of 1 to 10 (with 10 being unbearable):_____

_____

Have you sought previous treatment for this condition? _____ Where? _____ Results: _____

Are there any other issues you would like to discuss? Be specific. _____

_____

What does this prevent you from doing or enjoying?_____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ____ _____

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

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

Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____

Burning _____ Stabbing _____ Other _____

What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____

Lifting _____ Twisting _____ Other _____

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

Yes _____ No _____ Uncertain _____

Remarks: _____

_____

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

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

Doctor's Signature _____ Date _____

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	__Rheumatoid Arthritis
__Eating Disorder	__Depression/Anxiety	__Alcohol/Drug Addiction
__Diabetes	__Heart Disease	__High/Low Blood Pressure
__Stroke/TIAs	__Seizures/Convulsions	__HIV Positive
__A Congenital Disease	__Cancer	__Other_____

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

_____

What medications or drugs are you taking and for what purpose? (Please include any herbal supplements): _____

_____

Do you have any allergies of any kind? Yes__ No__ If yes, describe:_____

Please list any other health problems you have or anything else you would like for us to know:_____

_____

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 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 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:_____

FAMILY DISEASES

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease____
Arthritis_____	Liver Disease ____	Other: _____

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.
Please List any individuals that you authorize to have access to your records or to discuss your case.

Physicians: _____

Family Members: _____

Patient/ Guardian Signature:_____ Date:_____