Convergence Chiropractic Clinic

Chiropractic Case History/Patient Information

Date _____ Patient ID _____

Name _____ Social Security #_____ Phone _____

Address_____City_____ State_____ Zip _____

Age_____ Birth Date_____ Marital Status: M S W D Occupation_____

Employer_____ Office Phone_____

Spouse_____ Occupation_____ Employer_____

Names and Ages of Children_____

Name of Emergency Contact_____ Phone_____

How were you referred to our office? _____

When doctors work together it benefits everyone. Please list the name of any other healthcare/fitness professional you authorize your doctor to communicate with. Name of medical doctor_____

Name of fitness/exercise professional _____

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_____ Insured's ID# _____

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 payers 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, logistical 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_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint (purpose of this appointment) _____

Date symptoms appeared or accident happened _____

Is this due to Auto_____ Work_____ Other _____

Describe _____

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 _____

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 _____

Do you have any Congenital Condition? ___Yes ___ No

If yes, describe _____

Women - Are you pregnant at this time? _____

SOCIAL HISTORY

Please indicate beside each activity OFTEN = "O" SOMETIMES = "S" NEVER = "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Caffeine

_____ Other (specify) _____

_____

Patient ID

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

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	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____

Patient ID _____

FAMILY HISTORY

Please review the diseases and conditions listed below and indicate those that are current health problems. 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	MOTHER	SPOUSE	BROTHER	SISTER	CHILDREN
Arthritis						
Asthma/hay fever						
Back Pain						
Bursitis						
Cancer						
Constipation						
Diabetes						
Herniated Disc						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraines						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerves						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						

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

_____

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

Printed Name of Patient _____ Date _____

Printed Name of Guardian _____ Date _____

Signature _____ Date _____