

Chiropractic Case History/Patient Information

Date: _____

Personal Information

First: _____ Last: _____ Middle Initial: _____

Birth Date: ___/___/___ Age: _____ Sex: Male / Female Social Security #: _____ - _____ - _____

Marital Status: Single Married Widowed Divorced Separated Spouses Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work: (____) _____ - _____

Email Address: _____

Children (Names & Ages): _____

How did you hear about us? _____

Emergency Contact

First: _____ Last: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Relationship: _____

Employment Information

Business Name: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

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Insurance Information --if copy was made of your insurance card, please omit this section.

Primary Insurance Co.: _____ Policy Holder's Name: _____

Policy Holder's Social Security #: _____ - _____ - _____ Policy Holder's DOB: ___/___/___

Secondary Insurance Co.: _____ Policy Holder's Name: _____

Policy Holder's Social Security #: _____ - _____ - _____ Policy Holder's DOB: ___/___/___

Current Health Condition

Chief Complaint- What is your purpose for 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: _____

Family Medical Doctor: _____

Clinic Name/Address: _____

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

Past Medical History

Have you ever been diagnosed as having or have suffered from? (Please mark any & all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Ruptures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Migraines | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Head Injury |

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 and dates: _____

Have you been treated for any health condition by a physician in the last year? Yes _____ No _____

... If yes, describe: _____

Have you previously seen a Chiropractor? _____ If so, how recently? _____

Have you been treated by any physician for THIS condition? _____ If so, when? _____

Please list current medications:

Medication	Dosage	For what condition	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Parents:

Father: living _____ age _____ deceased _____ cause of death and age at death _____

Mother: living _____ age _____ deceased _____ cause of death and age at death _____

Adopted as a child, little is known of birth parents or family: _____

Do you have any family members who suffer from the same condition you do (back pain, headaches, etc.)? If so, please list: _____

Family Diseases (check any & all that apply and indicate **F**ather, **M**other, **S**ister, and **B**rother):

- | | | |
|--------------------|----------------------|---------------------------|
| Tuberculosis _____ | Cancer _____ | Mental Illness _____ |
| Diabetes _____ | Asthma _____ | Heart Disease _____ |
| Stroke _____ | Kidney Disease _____ | Lung Disease _____ |
| Arthritis _____ | Liver Disease _____ | Parkinson's Disease _____ |
| Other _____ | | |

Social History

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? _____ If so, how much per day? _____

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

Do you consume caffeine? _____ If so, how much per day? _____

Do you exercise? _____ If so, what is the frequency & type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting _____ sitting _____ bending _____ work at a computer _____

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, 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

Print Patient Name: _____

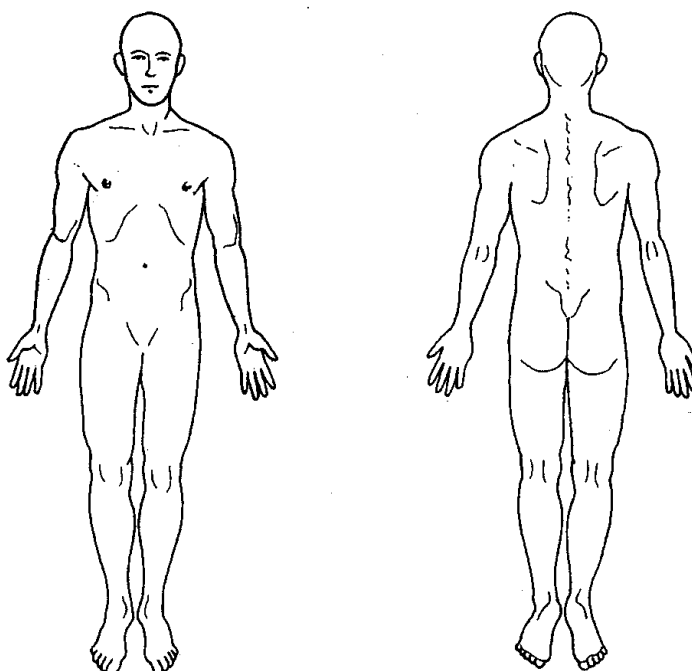
Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____

Tell us where you hurt.

Mark the areas on your body where you feel your pain. Include all affected areas. Also, Mark areas of radiation. If your pain radiates, draw an arrow from where it starts 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 o o
- Burning x x x x x x
- Stabbing // // // //
- Throbbing ~ ~ ~ ~ ~



SUMMARY

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
 How did it originally occur? _____
 Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
 If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only _____
 How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
 Yes _____ No _____. If yes, describe: _____
 Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____

6. Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____
 Burning _____ Stabbing _____ Other _____
7. 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? _____

8. What makes the problem worse? Standing _____ Sitting _____ Lying _____ Bending _____
 Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____

10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
 Yes _____ No _____ Uncertain _____
11. Have you ever been to a chiropractor before? Y_____N_____ When_____
12. Remarks: _____

NO
SYMPTOMS

EXTREME
SYMPTOMS



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

INFORMED CONSENT

PATIENT NAME _____

United Health Chiropractic
Dr. Ryan Schroeder D.C.
3212 14th Ave. S. Suite 2
Fargo, ND 58103
P: 701-232-2662
F: 701-232-9588

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

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Date _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)