Chiropractic Case History/Patient Information

Date:__________________ Patient #___________ **Doctor:**___________________

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:_________________________________

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:

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company:____
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 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. 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 ____________________ Doctor__________________________

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____

Have you ever had the same or a similar condition? π Yes π 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? π Yes π No

If yes, describe:____

What medications or drugs are you taking?____

____

Do you have any allergies to any medications? π Yes π No

If yes, describe:____

Do you have any allergies of any kind? π Yes π No

If yes, describe:____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe ______________________________

Women: Are you pregnant?___________________

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

Condition		Condition	
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	___________

PATIENT NAME ____

DATE ____________________ Doctor__________________________

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	________	Depression	__________
Ulcers	________		

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)______

____

____

PATIENT NAME ____

DATE ____________________ Doctor__________________________

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/Legal Guardian ____

Date ____

DOCTOR ______________________________

DATE OF VISIT ___/___/20___ Patient______________________________ Age______________

Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

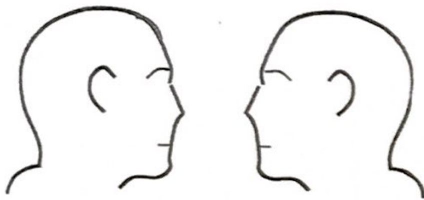
FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ______________

FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? ______________

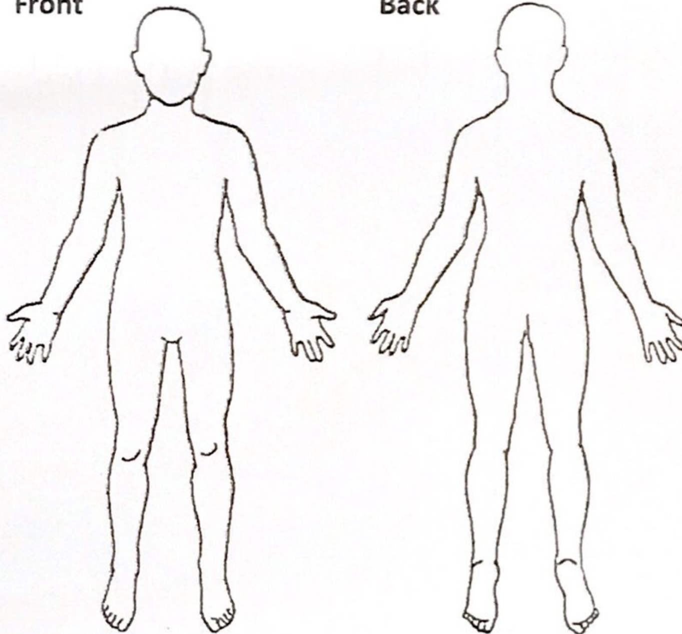
5

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

______________________________ ______________

Informed Consent

Every type of health care is associated with some risks of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in California.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine (drop table). Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Neck Artery Dissection and Stroke: *Dissection* is when the lining of a neck artery breaks down. This might happen spontaneously or from an injury or from a trivial movement (hair shampooing, checking traffic, looking up, etc.). *Dissections* tend to cause neck pain and/or headache. Dissections may form a clot that can dislodge and interfere with brain blood flow. If that happens, it is called a *stroke*. *Stroke* means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with *stroke* or not. Recent evidence suggests that it is not (2008, 2015, 2016, 2019), although the same evidence often suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous *dissection* of a neck artery. There are ***no*** in-the-office tests to diagnose a spontaneous neck artery *dissection* (2020), but they might be detectable with advanced imaging (CT/MRI, etc.). If we think you may be suffering from a spontaneous neck artery *dissection* and/or associated *stroke*, you will be immediately referred to emergency services.

Anecdotal cases suggest that chiropractic adjustments may be associated with *dissection* and/or *stroke* that arise from the vertebral artery; this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called the "extension-rotation-thrust atlas adjustment." We do not do this type adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of complication ranges between 1 per every 400,000-10,000,000 neck adjustments (2004). A large 10-year study estimated an incidence of 1 per 5.85 million neck adjustments, equivalent to 1,430 years if clinical practice (2001). If you experience any of the "5 **D**s **A**nd 3 **N**s" (on a following separate page) before, during or after an adjustment, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Two other potential problems that are *not* quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury, and spinal dural leak of cerebral spinal fluid.

Disc Herniations: Both neck and back disc herniations may create pressure on the spinal nerve or on the spinal cord. They are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. Occasionally chiropractic treatment (adjustments, traction, etc.) may aggravate a disc/nerve problem and rarely surgery may become necessary for correction.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual

organs (the saddle area), or the inability to start/stop urination or to start/stop a bowel movement. Cauda Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be as short as 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Rarely, chiropractic care may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

Rib and other Fractures: Rarely a chiropractic adjustment may crack a rib bone, and this is referred to as a fracture. We adjust all patients very carefully, and especially those who have known osteoporosis. Other fraction locations are extremely rare but possible, especially in those aged over 65 years and/or on steroid drugs.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat or ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. Never put an ice pack directly on the skin, always have an insulating towel between. We use *cold (low-level) laser therapy* which produces no heat and cannot result in burn.

Soreness: It is common for chiropractic care to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you for additional diagnostics or to another provider whom we feel will assist your situation.

Alternatives to chiropractic care include: do nothing, drugs, surgery, acupuncture, massage, etc. Risks from these procedures should be discussed with that particular provider.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

______________________________ ______________________________

Patient's Name Printed | Today's Date

______________________________ ______________________________

Patient's Signature | Parent or Guardian Signature For Minor

______________________________ ______________________________

Doctor's Signature Verifying Discussion | Date