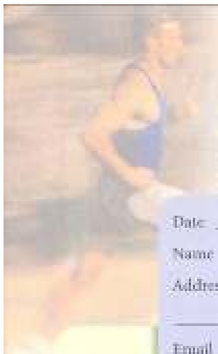


Case History Update

Welcome Back

In order for us to best serve you and bring your original case history up to date, please provide us with the following information. PLEASE PRINT.

HIPAA
Protected Health Information
Authorized Access Only

Date ____________ Patient/Clinic ID# ____________ Social Security # ____________

Name ____________ Date of Birth ____________

Address ____________ Home Phone ____________

____________ Work Phone ____________

Email ____________ Cell / Pager ____________

1) Is your visit today due to an accident? ❑ Yes ❑ No

2) List present complaints / pain / regions.

Neck ____________

Mid-Back ____________

Low Back ____________

Hips ____________

Arms/Legs ____________

Other ____________

3) Duration of present condition / pain.

____

____

4) What do you believe caused this?

____

____

____

____

5) Describe any falls, injuries or accidents.

____

____

____

____

6) Since your last visit here, have you consulted another doctor/hospital?

❑ Yes ❑ No ❑ Why ____________

Doctor's Name ____________ ❑MD ❑DO ❑DC

Doctor's Address ____________

Treatment received ____________

Medications ____________

____

Therapies ____________

____

Office Information Only: Past Diagnosis ____________

____

Last Exam ____________ Last X-rays ____________

____

Last VSC Levels: Occ C1 2 3 4 5 6 7 (8) / T1 2 3 4 5 6 7 8 9 10 11 12 (13)
L1 2 3 4 5 (6) / SAC / Coccyx / Hips Rt Lt

The clinic policy requires payment for all clinical services at time of service. Person responsible for payment:

Name ____________

Address ____________

____

Phone ____________

Do you have Insurance? ❑ Yes ❑ No

Company ____________

Address ____________

____

Phone ____________

Policy # ____________

Policy Holder (Name) ____________

Date of Birth ____________

ID # ____________

Insurance Effective Dates ____________

AUTHORIZATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat any condition as he/she deems appropriate through the use of Chiropractic Health Care. I give authority for all of these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for the examination only and the X-ray negatives will remain the property of this office. I also agree that I am responsible for all bills incurred at this office.

____
Patient Signature *Date*

____
Guardian or Parent Signature Authorizing Care *Date*

Patient Updated Pain Drawing

CONFIDENTIAL

HIPAA
Protected Health Information
Authorized Access Only

Doctor ______________________________

Patient ______________________________

Patient/Clinic ID # ______________________________

Accident? ❑ Yes ❑ No   Type: ❑ Auto Collision ❑ Personal Injury ❑ Worker's Compensation

Reason for Visit ______________________________

Symptoms Started ______________________________

Symptoms Getting Worse ❑ Yes ❑ No ❑ Same

Last Visit in Clinic __________ Last Doctor Visit __________ Last Exam / X-ray __________

PATIENT UPDATED PAIN DRAWING

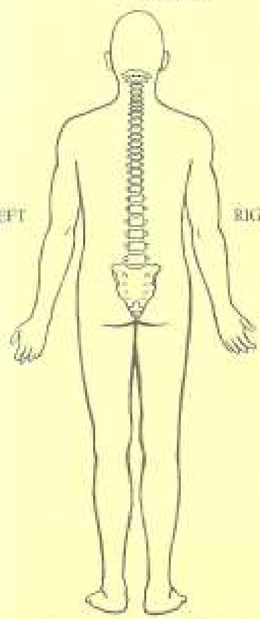
MARK PAIN AREA

+++ = Burning
OOO = Stabbing
--- = Sharp
III = Constant
XXX = Other

MARK AREA

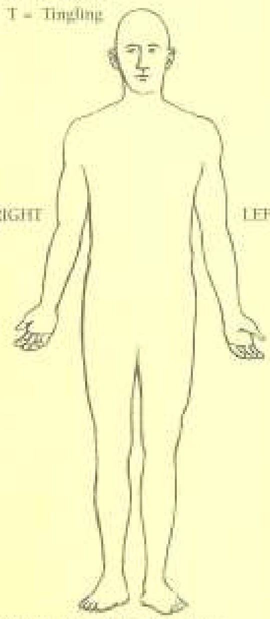
A = Ache
N = Numbness
P = Pain
S = Soreness
SF = Stiffness
T = Tingling

LEFT



RIGHT

RIGHT



LEFT

Please mark area of pain on the drawing using the code listed above.

SEVERITY OF PAIN

List region of pain and circle severity number
(1 = least, 10 = greatest)

ex. Neck ____sharp____
1 2 3 4 5 6 7 (8) 9 10

REGIONS

Neck ______________
1 2 3 4 5 6 7 8 9 10

Mid Back ______________
1 2 3 4 5 6 7 8 9 10

Low Back ______________
1 2 3 4 5 6 7 8 9 10

Hips ______________
1 2 3 4 5 6 7 8 9 10

Arms ______________
1 2 3 4 5 6 7 8 9 10

Legs ______________
1 2 3 4 5 6 7 8 9 10

Previous Neck Pain # ____ Pain Now #____
Previous Mid-Neck Pain # ____ Pain Now #____
Previous Low-Back Pain # ____ Pain Now #____
Previous Hip Pain # ____ Pain Now #____
Previous Arm Pain # ____ Pain Now #____
Previous Leg Pain # ____ Pain Now #____

HELPS	POSITION	HURTS	HELPS	POSITION	HURTS	HELPS	POSITION	HURTS
❑	Bending Backward	❑	❑	Lying on Side	❑	❑	Walking	❑
❑	Bending Forward	❑	❑	Sitting	❑	❑	Other: Describe:	❑
❑	Bending Leg	❑	❑	Standing	❑			
❑	Driving	❑	❑	Stretching	❑			
❑	Lifting	❑	❑	Stretching Leg	❑			
❑	Lying Face Down	❑	❑	Turning Body	❑			
❑	Lying on Back	❑	❑	Turning Head	❑			

____

____

____

Doctor's Signature ______________ Date