

Webster Chiropractic and Rehab

Chiropractic Case History - Patient Information

Date: _____ Doctor: Webster

Last Name: _____ First Name: _____ SS # _____

Home Phone: (____) _____ Daytime Phone: (____) _____

Cell Phone: (____) _____ Please check which phone you prefer us to use

Address: _____ City: _____ State: ____ Zip: _____

E-mail address: _____ Fax # _____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

How were you referred to our office? _____

Family Medical Doctor: _____ Phone: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your visit and our findings? YES NO

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Have you ever had the same or a similar condition? YES NO

If yes, when and describe: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a letter N or P by conditions that apply to you. Place an N if currently an issue - P for past issue).

- __ Broken or Fractured Bones __ Osteoarthritis __ Eating Disorder
__ Circulatory Problems __ Epilepsy __ Alcoholism
__ Rheumatoid Arthritis __ Pace Maker __ Drug Addiction
__ Seizures/Convulsions __ Strokes __ HIV Positive
__ A Congenital Disease __ Cancer __ Gall Bladder
__ Excessive Bleeding __ Ruptures __ Depression
__ High/Low Blood Pressure __ Coughing Blood __ Ulcers

(Use the back of this sheet if more space is needed for any questions)

Do you have a history of stroke or hypertension? YES NO Family Member history? YES NO

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

Are you taking any medications or drugs? YES NO If yes, please list: _____

Do you have any known allergies to any medications? YES NO If yes, describe:

Do you have any allergies of any kind? YES NO If yes, describe:

Please list any other health problems you have, no matter how insignificant they may seem:

SOCIAL HISTORY:

Do you drink alcoholic beverages? YES NO If so about how much per week? _____

Do you use any tobacco products? YES NO

Do you smoke cigarettes? YES NO If so, packs per day: _____

Do you take vitamin supplements? YES NO If so, please list: _____

Do you consume caffeine? YES NO If so, how much per day: _____

Do you exercise regularly? YES NO If yes, what is the frequency and 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 _____ working at a computer _____

FAMILY HISTORY:

Do you have any family members who suffer from the same condition you do? YES NO

If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

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

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.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____