Family First Chiropractic Clinic
119 W 2nd St. Ottumwa IA 641-954-8598
Chiropractic Case History/Patient Information

Patient Name:_________________________________ Social Security #_____________________________
Address:____City:________________ State:_____ Zip:_________
E-mail address:____ Phone:_______________________________
Age:_________ Birth Date:_________________ Race:_________________ Marital Status: 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:
( ) Major Medical ( ) Worker's Compensation ( ) Medicaid ( ) Medicare ( ) Auto Accident ( ) Medical Savings Account & Flex Plans ( ) 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 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. The following person(s) have my permission to receive my personal health information:
____
____

Patient's Signature:____Date:______________

Guardian's Signature Authorizing Care:____Date:____________

Date:_______________ **Patient Name**_________________________ **Doctor**:________________

HISTORY OF PRESENT AND PAST ILLNESS:
Major symptom/Purpose of this appointment:____
What does this prevent you from doing or enjoying____
Date symptoms appeared or accident happened:____
Is this due to: Auto___ Work____ Other____
Have you ever had the same or a similar condition? ( ) Yes ( ) No If yes, when and describe:
____
Please describe your pain/discomfort (sharp, dull, ache, throbbing, tingling, numb, stabbing, burning):____
Does the pain radiate down your arms or legs?____
Select frequency you experience pain :( )always ( )hourly ( )daily( )occasional
Is the pain/discomfort worse at a certain time of day? ( ) Yes ( ) No If yes, explain________________
Has it become worse recently? ( ) Yes ( ) No ( ) Same ( ) Better ( ) Gradually Worse
Does this condition interfere with any of your daily activities or routines? ( ) Yes ( ) No
Has this condition affected your quality of sleep or ability to sleep? ( ) Yes ( ) No
Has this condition affected your appetite? ( ) Yes ( ) No
List anything that makes the pain/discomfort worse: ( )Bending ( ) Lifting ( ) Twisting
____
List anything that relieves or improves your condition: ( ) Ice ( ) Heat ( ) Rest ( ) Ibuprofen
____
Have you received professional treatment for this condition? ( ) Yes ( ) No If yes, explain:
____
Have you had x-rays for this condition? ( ) Yes ( ) No. If yes, where?_____________________________
On a scale 1 to 10 (Where 1 is least pain & 10 is maximum pain) please rate the following:
Condition at its best __________Condition at its worst __________Current level of pain/discomfort __________
Days lost from work: _______________ Date of last physical examination:___________________________
Do you have a history of cancer, 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? ________________________ If yes date of last menstrual cycle ________________
Any additional areas of complaint or information____
____
____

Date:_______________ **Patient Name**_________________________ **Doctor**:________________

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

Headaches______ Frequency _________
Neck Pain ________
Stiff Neck ________
Sleeping Problems ________
Back Pain ________
Nervousness ________
Tension ________
Irritability ________
Chest Pains/Tightness ________
Dizziness ________
Shoulder/Neck/Arm Pain ________
Numbness in Fingers ________
Numbness in Toes ________

Loss of Balance ________
Fainting ________
Loss of Smell ________
Loss of Taste ________
Unusual Bowel Patterns ________
Feet Cold ________
Hands Cold ________
Arthritis ________
Muscle Spasms ________
Frequent Colds ________
Fever ________
Sinus Problems ________
Diabetes ________

High Blood Pressure ________
Difficulty Urinating ________
Weakness in Extremities ________
Breathing Problems ________
Fatigue ________
Lights Bother Eyes _________
Ears Ring _________
Broken Bones/Fractures _________
Rheumatoid Arthritis _________
Excessive Bleeding _________
Osteoarthritis _________
Pacemaker _________
Stroke _________
Ruptures _________
Eating Disorder _________
Drug Addiction _________
Gall Bladder Problems _________

Indigestion Problems ________
Joint Pain/Swelling ________
Menstrual Difficulties ________
Weight Loss/Gain ________
Depression ________
Loss of Memory ________
Buzzing in Ears ________
Circulation Problems ________
Seizures/Epilepsy ________
Low Blood Pressure ________
Osteoporosis ________
Heart Disease _________
Cancer _________
Coughing Blood _________
Alcoholism _________
HIV Positive _________
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

_____Family Pressures
_____Financial Pressures
_____Other Mental Stresses
_____Other(specify)________
____

Date:________________ **Patient Name**__________________________ **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. Please specify relation i.e. Father, mother, spouse, brother, sister, child.

Arthritis			
Asthma	__________________		
Back Trouble	__________________	Insomnia	__________________
Bursitis	__________________	Kidney Trouble	__________________
Cancer	__________________	Liver Trouble	__________________
Constipation	__________________	Migraine	__________________
Diabetes	__________________	Nervousness	__________________
Disc Problem	__________________	Neuritis	__________________
Emphysema	__________________	Neuralgia	__________________
Headaches	__________________	Pinched Nerve	__________________
Heart Trouble	__________________	Scoliosis	__________________
High Blood Press.	__________________	Sinus Trouble	__________________
	__________________	Stomach Trouble	__________________

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 ____