Chiropractic Case History/Patient Information

Date:________________ How did you hear about Bixby Chiropractic?_______________

Name:_____________________ Social Security #: _________________Home Phone #:___________________
Address:________________________________ City:________________ State:________ Zip:_____________
E-mail address:________________________ Fax #:__________________ Cell 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 #:______________
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 officer?____________________

HISTORY OF PRESENT 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 similar condition? [ ]Yes [ ]No If yes, when and describe:_______________
____
Days lost from work:___________________ Date of last physical examination:___________________________

PAST MEDICAL HISTORY
Have you ever been diagnosed as having or have suffered from: (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones
__Circulatory Problems
__Rheumatoid Arthritis
__Seizures/Convulsions
__A Congenital Disease
__Urinary Incontinence
__High/Low Blood Pressure

__Osteoarthritis
__Epilepsy
__Pace Maker
__Ulcers
__Excessive Bleeding
__Strokes
__Ruptures
__Coughing Blood

__Eating Disorder
__Alcoholism
__Lupus
__HIV Positive
__Gall Bladder
__Depression
__Diabetes
__Drug Addiction

__Cancer/Tumors (specify):________________
__Pancreatic Disease (specify):________________
__Heart Disease (specify):________________

Do you have a history of stroke or hypertension?____

Do you smoke? No Yes If Yes, how much per day?____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):____

Are you, or do you think, you might be pregnant? [ ]Yes [ ]No

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? Women, please include birth control:_________________________
____

How many days a week do you exercise? [ ]none [ ]1-2 [ ]3-4 [ ]5-7

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:____

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

Please check any and all insurance coverage that may be applicable in this case:
[ ] Major Medical [ ] Worker's Compensation [ ] Medicaid [ ] Auto Accident
[ ] Medical Savings Account & Flex Plans [ ] Other

Name of Primary Insurance Company:____
Name of Secondary Insurance Company:____
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 to 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.

Patient's Signature:____ Date:___________________
Guardian's Signature Authorizing Care:_______________________________ Date:___________________