



RBCWC Chiropractic Case History/Patient Information

Name: _____ S.S. # _____ Home Phone: _____
Address: _____ City: _____ State: _____
Zip: _____ E-mail address: _____ Cell Phone: _____
Age: _____ Birth Date: _____ Marital Status: M S W D T-shirt size ___ shorts size ___
Occupation: _____ Employer: _____
Employer's Address: _____ Office Phone: _____
Spouse: _____ Occupation: _____
Employer: _____
How many children? _____ Names and Ages of Children: _____
Name of Nearest Relative / Emergency Contact: _____
Address: _____ Phone: _____
How did you hear about 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? Yes / No

Please check any and all insurance coverage that may be applicable in this case:
____ Major Medical ____ Worker's Compensation ____ 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 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.

Patient Name _____ Date _____





We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. For 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 always available at our front desk.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations; the chiropractic physician has the right to refuse to give care.

***I have read and understand how my Patient Health Information will be used
and I agree to these policies and procedures.***

Patient's or Guardian's Signature: _____ Date: _____





Patient Name _____ Date _____

HISTORY OF PRESENT AND PAST ILLNESS:

What are your health and fitness goals: _____

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? Yes / 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? Yes / No
If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes / No If yes, please describe. _____

Do you have any allergies of any kind? Yes / No If yes, please describe: _____

Do you have any Congenital Conditions? ___Yes ___ No If yes, please describe _____

Women: Are you pregnant? Yes / No / Unsure





Patient Name _____ Date _____

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 _____	How often? _____	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	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
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	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____		
Ulcers	_____		





Patient Name _____ Date _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
 OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise	_____ Family Pressures
_____ Moderate Exercise	_____ Financial Pressures
_____ Alcohol Use	_____ High Stress Activity
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____

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(s):	SISTER(S) Age(s):	CHILDREN Age(s):
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Condition						
High Blood Pressure/ Hypertension						
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 _____

