Ghent Chiropractic

Chiropractic Case History/Patient Information

Date: _____ Patient #_____

Name: _____ Social Security #_____Home Phone: _____

Address: _____City:_____ State:_____ Zip:_____

E-mail address:_____ Fax # _____ Cell Phone:_____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D Children: Yes □ No □

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ 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? Yes □ No □

Please check any and all insurance coverage that may be applicable in this case**:**

□ Major Medical □ Worker's Compensation □ Medicare □ Auto Insurance
□ Health 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 Ghent Chiropractic, PC. 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:_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared, injury occurred, or accident happened: _____

Is this due to: Athletic Injury □ Auto Accident □ Other _____

Have you ever had the same or a similar complaint? □ Yes □ No If yes, when and describe: _____

_____

Has the problem recently changed in intensity or frequency? Yes □ No □ No Change □ Worsening □ Improving □

How often does the problem occur: Constantly □ Frequently □ Intermittently □ Occasionally □ Only with exercise □

Duration of problem when symptomatic: All day□ Several hours□ Several minutes□ Several seconds□ No pattern□

Describe the symptom(s): Sharp □ Dull □ Ache □ Sore □ Numbness □ Tingling □ Stabbing □ Stiff □ Weak □

Other: _____

At its most severe what would you rate your level of discomfort: 0 (no symptom) 10 (severe symptoms) _____

At its least severe what would you rate your level of discomfort: 0 (no symptom) 10 (severe symptoms) _____

Does anything make the problem worse? Exercise □ Standing □ Sitting □ Lifting □ Bending □ Twisting □

Other: _____

Does anything make the problem better? Exercise □ Standing □ Sitting □ Moving □ Stretching □ Rest □

Other: _____

Days unable to perform physical activity and which activities you are unable to perform:

_____

Any other symptoms or conditions that may be related to your chief complaint: _____

Any other unrelated health problems: _____

Days lost from work: _____ Date of last physical examination: _____

History of sports injuries, fractures, or significant falls or accidents that may or may not have required surgery:

_____

Do you have a history of stroke or hypertension? _____

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

_____

_____

Have you been treated for the problem which you are presenting to our office or any other health condition by a physician in the last year? Yes □ No □

If yes, describe: _____

What nutritional supplements, medications or drugs are you taking? _____

_____

Do you have any allergies to any foods or medications? Yes □ No □

If yes, describe: _____

Do you have any allergies of any kind? Yes □ No □

If yes, describe: _____

Do you have any congenital conditions? Yes □ No □ if yes, describe _____

To your knowledge have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or present? Yes □ No □ If yes, please explain _____

Women: Are you pregnant or is there any possibility you may be pregnant? Yes □ No □

Athletic History Profile (If applicable)

What types of sports are you currently involved in and how many years have you been performing these activities?

_____

What type of sports have you been involved in the past? _____

How often do you exercise? Daily □ Every other day □ Every few days □ Weekly □ Occasionally □ Never □

What type of exercises do you regularly perform? Running □ Swimming □ Cycling □ Lifting Weights □ Walking □ Other: _____

Average weekly distance or duration: Running _____ Cycling _____ Swimming _____

Current weekly distance: Running _____ Cycling _____ Swimming _____

Running shoes: Type _____ Brand _____ Style _____

Do you wear orthotics? Yes □ No □ If so, who prescribed and fitted the orthotics? _____

Are you training for a specific goal? 10k, ½ marathon, marathon, Ironman, etc.…._____

Do you stretch or use a foam roller? Yes □ No □ If yes, how often and when? _____

Do you use any system of home rehab/ strengthening? _____

Any previous athletic injuries not previously mentioned? _____

I certify the information provided is accurate to the best of my knowledge:

Name of patient _____

Signature of patient/legal guardian _____ Date _____

Doctor's signature _____ Date _____