

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: _____ Height: _____ Weight: _____

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 complaint appeared, injury occurred, or accident happened: _____

Is this due to: Athletic Injury Auto Accident Other (Please explain) _____

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

Has the primary complaint recently changed in intensity or frequency? Yes: Worsening Improving No Change

How often does the primary complaint occur: Constantly Frequently Intermittently Occasionally Only with exercise

Duration of primary complaint 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 in this area: 0 (no symptom) 10 (worst pain imaginable) _____

At its least severe what would you rate your level of discomfort in this area: 0 (no symptom) 10 (worst pain imaginable) _____

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

Other: _____

Does anything make the discomfort 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 or unrelated to your chief complaint: _____

Any other 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 any other health provider in the last year? Yes No

If yes, describe type of provider and treatment: _____

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 long 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 Strength Training
Walking Crossfit 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? Yes No If yes, how often and when? _____

Do you use a foam roller or mobility ball? Yes No If yes, how often & when? _____

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

Any previous athletic injuries not previously mentioned? _____

Have you ever received chiropractic care previously? Yes No If yes, please describe when and for what reason?: _____

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 _____