Chiropractic Case History/Patient Information

Date: _____

Name:_____ Social Security #_____ Home Ph:_____

Address:_____ City: _____ State: _____ Zip:_____

Email Address:_____ Cell Ph:_____

Age:_____ DOB:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Ph:_____

Spouse:_____ Occupation:_____ Employer:_____

How Many Children?_____ Names /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? _____

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 may apply to you)

____Broken/Fractured Bones	____Osteoarthritis	____Eating Disorder
____Circulatory Problems	____Epilepsy	____Alcoholism
____Rheumatoid Arthritis	____Pace Maker	____Drug Addiction
____Seizures/Convulsions	____Strokes	____HIV Positive
____A Congenital Disease	____Cancer	____Gall Bladder
____Excessive Bleeding	____Ruptures	____Depression
____High/Low Blood Pressure	____Coughing Blood	____Ulcers

Do you have a history of stroke/hypertension? _____

Have you had any major illnesses, injury, 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: _____

_____

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

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____
Do you use any tobacco products? ___ Do you smoke? ____ If so, packs per day:_____
Do you take vitamin supplements? ____ If so, please list:_____
Do you consume caffeine? ___ If so, how much per day:_____
Do you exercise? ____ If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend: Lifting____ sitting_____ bending_____ working at a computer_____

FAMILY HISTORY:

Parents:
Father: Living____ deceased____ current age if still living:____ Cause of death and age at death if deceased:_____(check one)

Mother: Living____ deceased____ current age if still living:____ Cause of death and age at death if deceased:_____(check one)

Check if applicable to you:_____ As an adopted child, little is known of birth parents or family.
Do you have any family members who suffer from the same condition you do? If so, please list:_____

FAMILY DISEASES (Check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis ___	Cancer___	Mental Illness____
Diabetes____	Asthma___	Heart Disease____
Stroke___	Kidney Disease____	Lung Disease____
Arthritis____	Liver Disease____	

Other_____

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 Plan * 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.

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 HIPPA 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 Authorized Care:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (Please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Dr. Marshall Webb, D.C.
3430 Cleveland Avenue
Fort Myers, FL 33901
(239) 936-2889 FAX (239) 689-1765

I authorize my insurance company to pay Marshall Webb, D.C. directly. I also authorize the release of information regarding my records to my insurance company and my attorney.

SIGNED _____

DATE _____