Chiropractic Case History/Patient Information

Date________________ Patient # ______________ Dr. Hall_______________

Name__________________________Social Security # _________________Home Phone ___________

Address ______________________________City _______________State_________ Zip ___________

E-mail address: ______________________________ Fax # ____________ Cell Phone ___________

Age _______ Birth Date _________ Race ________Marital: M S W D How many children? _____

Occupation _________________________________Employer _______________________________

Employer's Address _______________________________________ Office Phone_____________

Spouse ___________ Occupation ________________Employer ________________________________

Name of Nearest Relative_______________________Address__________________Phone _______

How were you referred to our office? ____

Family Medical Doctor ____

Purpose of this appointment ____

Date symptoms appeared or accident happened ______________________________________

Have you ever had the same or a similar condition? p Yes p No If yes, when and describe: ______

____

Days lost from work ___________________

Date of last physical examination _____________What surgeries have you had? (Include dates) _______

____

Serious illnesses (include dates)____

____

Have you been treated for any health condition by a physician in the last year? p Yes p No

If yes, describe: ____

____

What medications or drugs are you taking? ____

____

Please check any and all insurance coverage that may be applicable in this case.
p Major Medical p Worker's Compensation p Medicaid p Medicare p Auto Accident p Other

Name of Primary Insurance Company____

Name of Secondary Insurance Company (if any)______________________________________

AUTHORIZATION AND RELEASE: Fees are payable at the time X-rasy, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of Hall Chiropractic Center, P.A. 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 understand that my insurance company may occasionally deny payment of services that my physician and/or I feel are necessary for my good health. 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Continued on next page

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__________

Office Use Only
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☐ 4-5
☐ >5

Patient #:___________________

Pain Drawing

Name:_____________________________________ Date:____________________________

Date of Birth:_____________________________ Examiner:________________________

TELL US WHERE YOU HURT.

Please read carefully:
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~