

Chiropractic Case History/Patient Information

Date: _____ **Patient #** _____ **Doctor:** _____
Name: _____ **Social Security #** _____ **Home Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
E-mail address: _____ **Cell Phone:** _____
Age: _____ **Birth Date:** _____ **Sex:** _____ **Marital:** M S W D
Occupation: _____ **Employer:** _____
Employer's Address: _____ **Office Phone:** _____
Spouse: _____ **Occupation:** _____ **Employer:** _____
How many children? _____ **Names and 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? _____

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 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.

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 or accident happened: _____

Is this due to: Auto___ Work___ Other_____

Have you ever had the same or a similar condition? π Yes π 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? π Yes π No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? π Yes π No

If yes, describe: _____

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

If yes, describe: _____

Do you have any Congenital Condition? ___ Yes ___ No If YES, Describe _____

Women: Are you pregnant? _____

PREGNANCY WAIVER

I hereby acknowledge that Dr. Marc Vein of Fargo Spine and Rehabilitation has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Printed Name of Patient

Signature of Patient/Authorized Representative of Patient

Witness

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_____ Frequency _____		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 _____
Lights Bother Eyes _____		Loss of Memory _____
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 _____		

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	_____ Other Mental Stresses
_____ Drug Use	_____ Other (specify)_____
_____ Tobacco Use	_____
_____ Caffeine	_____
_____ High Stress Activity	

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	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
HighBlood Pressure									
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 _____

Pain Drawing

TELL US WHERE YOU HURT.

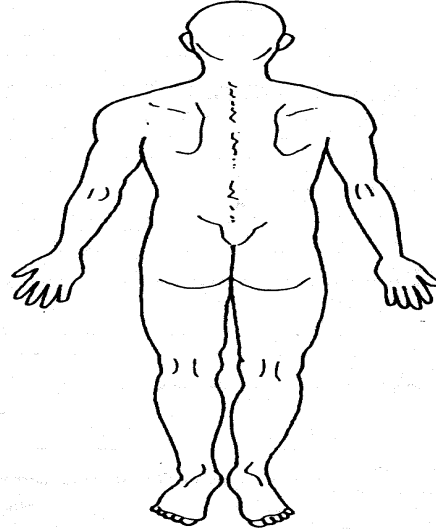
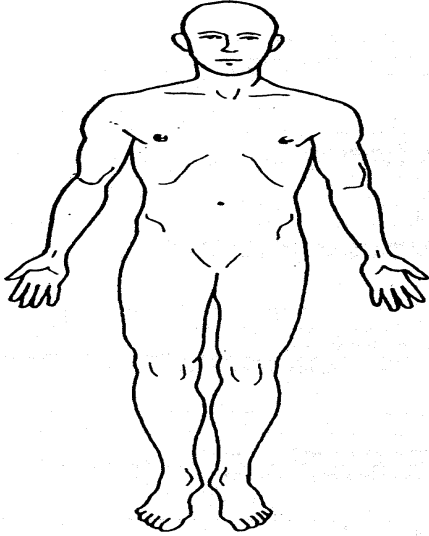
Please read carefully:

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 starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache-A
Burning-B

Numbness-N
Stabbing-S

Pins & Needles -P
Throbbing -T



INFORMED CONSENT

PATIENT NAME _____

Clinic Name Fargo Spine and Rehabilitation

Doctor's Name: Dr. Marc P. Vein, DC

Address 3222 28th St SW Fargo ND 58104

Phone: 701-232-4770 Fax: 701-237-3251 E-mail: clinic@fargospineandrehab.com

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)