HerringChiropractic

CASE HISTORY

Name: _____

Street/City/Zip: _____

Telephone: _____ **Cell Phone:** _____ **Email:** _____

Social Security # _____ **Age:**_____ **DOB:** _____ **Sex:** _____

Marital Status: _____ **Occupation**: _____ **Employer:** _____

Employer's Address: _____ **Phone:** _____

Spouse's Name: _____ **Referred By:** _____

What is your major complaint?_____

How long have you had this condition?_____

Other complaints: _____

Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ **Yes** ☐ **No** ☐ **Constant** ☐ **Comes and goes**

Is this condition interfering with your: Work☐**Sleep**☐**Daily Routine**☐**Other:** _____

List surgical operations: _____

Are you taking any medications? _____**What kind?** _____

Other doctors seen for this condition: _____

Doctor's Name: _____ **Diagnosis:** _____

X-Rays/MRI: _____ **Other:** _____

Treatment: _____

Were you off work? _____ **If so, how long?** _____

Have you returned to your same job? **If not, why?** _____

*****DID YOU HAVE A SPECIFIC ACCIDENT? (i.e. car accident, work injury, slip and fall)*****

Did your accident occur at work? _____ **Were you involved in an automobile accident?** _____

*** If you answered yes to either please let the staff know if you have not already done so***

By signing this form, you agree to allow us to bill your insurance if applicable.

Our office has a $25 now show/cancellation fee. If you need to cancel, we ask that you give us 24-hour notice to avoid the fee. By signing this form, you agree to this policy.

Patient's Signature _____ **Date:** _____

IMPORTANT: Please check (✔) all present symptoms. **NAME:**_____ **DATE:** _____

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears
- ☐ TMJ – Jaw pain

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R-L)
- ☐ Pain across shoulders
- ☐ Bursitis (R-L)
- ☐ Arthritis (R-L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R-L)
- ☐ Muscle spasms in shoulders

ARMS AND HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Arthritis in fingers
- ☐ Sensation of pins and needles in arms

ARMS AND HANDS (continued):
- ☐ Sensation of pins and needles in fingers
- ☐ Numbness in arms (R-L)
- ☐ Numbness in fingers (R-L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Loss of strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Irregular heartbeat
- ☐ Breast pain
- ☐ Dimpled or orange peel breast

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroiliac
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Pain relieves when _____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

HIPS, LEGS, AND FEET:
- ☐ Pain in buttocks (R-L)
- ☐ Pain in hip joint (R-L)

HIPS, LEGS, AND FEET (continued):
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R-L)
- ☐ Pins and needles in legs (R-L)
- ☐ Numbness of leg (R-L)
- ☐ Numbness of feet (R-L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R-L)
- ☐ Swollen feet (R-L)
- ☐ Pain in feet (R-L)
- ☐ Weakness in the leg (R-L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer
- ☐ Menopause

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/ swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _____
- ☐ Loss of sleep _____ hrs./ night
- ☐ Loss of weight _____ lbs.
- ☐ Weight gain _____ lbs.
- ☐ Coffee _____ cups/ day
- ☐ Tea _____ cups/ day
- ☐ Cigarettes ____pack/ day
- ☐ Other _____
- ☐ Diabetes
- ☐ Hypoglycemia

REMARKS:

_____

_____

_____

_____

HerringChiropractic

Informed Consent to Chiropractic Treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first days of treatment.

2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.

3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature **Print Name**

_____ _____

Date **Witness Signature (to be signed by office)**

Privacy Notice

I have received the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide the Doctors Office with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient name (Print)

_____ _____

Patient Signature **Date**

_____ _____

Authorized Facility Signature **Date**

If you would like a copy of the privacy notice for your records, please let the front desk staff know.

Our privacy notice is also available on our website.