Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Date: ______________________

File No.: ______________________

Birthdate: ______________ Age: ________

Name: ______________________ Social Security No.______ /______/______

Address: ____
(Street) (City) (State) (Zip)

Phone: ______________ Email: ______________________

Spouse: ______________________ Age: _____

Children (name and ages): ______________________

Whom may we thank for referring you?: ______________________

Previous Chiropractic Care: ______________________

Primary Care Physician: ______________________

Employer: ____
(Name) (Address) (Phone)

Occupation: ______________________

Insurance: ____
(Name) (Address)

Subscriber's Date of Birth: ______________ Name of Insured: ______________

Subscriber's Social Security Number: ______/______ /______

Is this an accident case?: ☐ Yes ☐ No

Major Complaint?______________________

Previous Care for Complaint: ______________________
(Doctor's Name)

How long have you had this condition? ______________________

Have you had this or similar conditions in the past? ☐ Yes ☐ No

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: ______________________

Drugs you now take: ☐ Pain Killers ☐ Muscle Relaxers ☐ Insulin ☐ Cholesterol ☐ Anxiety

☐ Blood Pressure ☐ Birth Control ☐ Other: ______________________

Habits (please give quantity)

Smoke: ____________ Alcohol: ____________ Sleep: ____________

Caffeine: ____________ Eating Habits: ____________

Past Illnesses (date, severity and type of injury)

Car Accidents: ____________

Serious Falls: ____________

Fractures: ____________

Surgery: ____________

Emotional Upsets: ____________

Recent Doctor Visits: ____________

Recent X-Rays: ____________

Are you aware of any family diseases: ____________

Now take vitamins or minerals? ☐ Yes ☐ No

Have an allergy to any drug? ☐ Yes ☐ No

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

GENERAL
- ☐ Allergy
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of weight
- ☐ Nervousness/Depression
- ☐ Neuralgia
- ☐ Numbness

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders
- ☐ Sciatica
- ☐ Swollen joints

GASTRO - INTESTINAL
- ☐ Belching or gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Hemorrhoids

CARDIO-VASCULAR
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart rate
- ☐ Swelling of ankles

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing

EYES, EARS & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Ear aches

FOR WOMEN ONLY
- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge

GENITO-URINARY
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Prostate trouble

CHECK THE FOLLOWING CONDITIONS YOU MAY HAVE:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Cancer
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

PLEASE READ OUR COPY OF HIPAA NOTICE OF PRIVACY PRACTICES LOCATED IN THE WAITING ROOM. OUR PRACTICE ADHERES TO ALL HIPAA POLICIES ENACTED IN 2003.

Chiropractic is covered by nearly all insurance policies, but policies vary from company to company. We will fill out insurance forms, however, the patient is directly responsible for payment of the bill, unless other arrangements are made in advance with the Doctor.

Signature: ____________

ST. CLAIR CHIROPRACTIC CLINIC, P.C.
HANRAHAN CHIROPRACTIC CENTER, P.C.
www.stclairchiropractic.com

Electronic Health Records Intake Form

The following questions are required as we transition to electronic medical records in accordance with a recent government mandate. Per HIPAA regulations your answers will be kept confidential. Thank you for your patience and understanding.

First Name: ________________________________ **Last Name**: ________________________________

Height: _________ **Weight:** ____________ **(Doctor Only: Blood Pressure:**_________ /________)

DOB: ___/___/_____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline To Answer / Other ________________________

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Patient Signature: ____ Date: ________________