Chiropractic Case History/Patient Information

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____ Cell Phone:_____ Age:_____

Birth Date:_____ Race:_____ Marital: M S W D Family Medical Doctor:_____

Occupation:_____ Spouse:_____ Occupation:_____

How many children?_____Names and Ages of Children:_____

_____

How were you referred to our office?_____Emergency Contact: (name/phone)_____

When doctors work together it benefits you. May we contact your medical doctor regarding your care at this office?_____ Contact info:_____

Please circle you preferred method of payment: Self pay Personal Health insurance Auto or workman's comp

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:_____

Major complaint/problem _____ When did you first notice the pain start _____

How did it originally occur?_____ Recently the pain has __improved __gotten worse __ stayed the same

What does this pain prevent you from doing? _____

How much water do you drink (in ounces) each day? _____ Do you drink Caffeine/How much? _____

Is this due to: Auto___ Work____ Do you have a history of stroke or hypertension?_____

Doctor Signature _____

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?_____

Please list any allergies (include medications):
Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Do you have any other health problems that you have not mentioned above?_____

The pain is: Sharp Dull Numbness Tingling Aching Burning Stabbing

What makes the pain go away? _____ What make the pain worse? _____

Please rank your pain when it is the worst: 1 2 3 4 5 6 7 8 9 10

Women: Are you pregnant?_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Vigorous Exercise	Moderate Exercise	Alcohol Use
Drug Use	Tobacco Use	
Family Pressures	Financial Pressures	Other Mental Stresses

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 _____
Neck Pain _____
Sleeping Problems _____
Back Pain _____
Tension _____
Irritability _____
Chest Pains/Tightness _____
Dizziness _____
Fever _____
Numbness in Fingers/toe _____
Diabetes _____
High Blood Pressure _____
Difficulty Urinating _____
Breathing Problems _____
Fatigue _____
Lights Bother Eyes _____
Ears Ring _____
Circulation Problems _____
Rheumatoid Arthritis _____
Excessive Bleeding _____
Osteoporosis _____
Pacemaker _____
Coughing Blood _____
Gall Bladder Problems _____

Loss of Balance _____
Fainting _____
Loss of Taste _____
Unusual Bowel Patterns _____
Hands/Feet Cold _____
Arthritis _____
Muscle Spasms _____
Shoulder/Arm Pain _____
Menstrual Difficulties _____
Sinus Problems _____
Weakness in Extremities _____
Indigestion Problems _____
Joint Pain/Swelling _____
Weight Loss/Gain _____
Depression _____
Loss of Memory _____
Broken Bones/Fractures _____
Alcoholism _____
Seizures/Epilepsy _____
Osteoarthritis _____
Ulcers _____
Heart Disease _____
Eating Disorder _____

Doctor Signature _____

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 Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Back Trouble						
Cancer						
Diabetes						
Disc Problem						
Emphysema						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Pinched Nerve						
Scoliosis						

INFORMED CONSENT

PATIENT NAME _____

Clinic Name Parker Performance Clinic

Doctor's Name Ben Lockie

Address 10490 Dransfeldt Parker Co 80134

Phone 720-277-3808 _____

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 compilations 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 oculosympathethetic 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 you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

Doctor Signature _____