Introduction Patient Case History

Name (Mr. Mrs. Miss Ms.): _____ Date: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Mobile Carrier: _____ Receive Text? Yes/No

Email: _____ Date of Birth: _____/_____/_____

Married/Single/Divorced/Widowed Social Security No: _____-_____-_____

Who (or what source) can we thank for your referral? _____

Emergency Contact: _____ Phone Number: _____

Number of Children: _____ Are You Pregnant?_____

Occupation:_____Employer:_____Work Phone:_____

Previous Chiropractic Care? Yes/No When: _____ Doctor's Name:_____

Any Recent Surgeries:_____ Date:_____ Description:_____

Medications:_____ Allergies to RX:_____

Any major illness past or present: (ex. diabetes, cancer etc.) _____

Any Recent Accidents: car/work/fall/other_____ Date:_____

	FAMILY HISTORY							
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other	
Mother	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	
Brother	☐	☐	☐	☐	☐	☐	☐	
Sister	☐	☐	☐	☐	☐	☐	☐	
Grandmother	☐	☐	☐	☐	☐	☐	☐	
Grandfather	☐	☐	☐	☐	☐	☐	☐	

Current work status: Working/Student/Retired/Homemaker Have you had to reduce work since injury Y/N

Smoking habits: Never smoked/Former smoker/Current smoker_____packs/day

Alcohol consumption: None/ Socially/ Habitually

How often do you exercise a week?_____

Any specific dietary needs/vitamins taken?_____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.

Patient Primary Complaint Form

Name: _____ Date: _____

Where is the pain? _____

When did your pain begin? _____

What event caused your pain? _____

Is your condition: Constant Frequent Occasional Intermittent

Type of pain: Sharp Stabbing Burning Achy Dull Stiff Sore

Shooting pain into: Left/Right Shoulder Arm Hand Other:_____

Left /Right Hip Leg Knee Foot Other:_____

Is your condition: Getting better Getting worse No change

Pain Level: Best 0 1 2 3 4 5 6 7 8 9 10 Worst

What makes it better? Ice Heat Rest Movement Stretching Exercise Medication Other:_____

What makes it worse? Sitting Standing Walking Lying down Sleep Overuse Bending Lifting Driving Turning Other:_____

When does it feel better? No Change Morning Mid-day Evening Night As the day progresses

When does it feel worse? No Change Morning Mid-day Evening Night As the day progresses

Have you experienced this condition before? Yes No When? _____

Have you been treated by anyone else for this condition? Yes No

If yes, whom? _____

Any recent diagnostic tests? MRI CT scan X-Ray Where ?_____

What activities have become more difficult?

_____

Medical History/Review of Systems

Musculoskeletal:
Past/Present
- ❑ ❑Neck pain
- ❑ ❑Mid Back pain
- ❑ ❑Low back pain
- ❑ ❑Shoulder pain
- ❑ ❑Pain in hand
- ❑ ❑Pain in upper leg
- ❑ ❑Pain in lower leg
- ❑ ❑Pain in ankle/foot
- ❑ ❑Swelling/Stiffness in joints
- ❑ ❑Arthritis
- ❑ ❑Other:

_____

Neurological:
- ❑ ❑Headache
- ❑ ❑Dizziness
- ❑ ❑Seizures
- ❑ ❑Ringing in ears
- ❑ ❑Difficulty swallowing
- ❑ ❑Depression
- ❑ ❑Fainting
- ❑ ❑Visual problems
- ❑ ❑Other:

_____

Head & ENT
- ❑ ❑Jaw pain
- ❑ ❑Sinus problems
- ❑ ❑Other:

_____

Cardiovascular:
Past/Present
- ❑ ❑Rapid heart rate
- ❑ ❑Chest pain
- ❑ ❑High blood pressure
- ❑ ❑Angina
- ❑ ❑Heart Attack
- ❑ ❑Stroke
- ❑ ❑History of multiple miscarriage or family history of multiple miscarriage
- ❑ ❑Other:

_____

Respiratory:
- ❑ ❑Chronic cough
- ❑ ❑Asthma
- ❑ ❑Emphysema
- ❑ ❑Other:

_____

Gastrointestinal:
- ❑ ❑Nausea
- ❑ ❑Loss of appetite
- ❑ ❑Excessive thirst
- ❑ ❑Stomach pain
- ❑ ❑Ulcers
- ❑ ❑Other:

_____

Genitourinary:
- ❑ ❑Painful urination
- ❑ ❑Frequent urination
- ❑ ❑Difficulty with bladder/bowels
- ❑ ❑Kidney stones
- ❑ ❑Kidney disorders
- ❑ ❑Gall stones
- ❑ ❑Prostate problems
- ❑ ❑Other:

_____

Endocrine:
Past/Present
- ❑ ❑Abnormal weight gain/loss
- ❑ ❑Thyroid problems
- ❑ ❑Chronic Fatigue
- ❑ ❑Diabetes
- ❑ ❑Other:

_____

Dermatological/ Hematopoietic:
- ❑ ❑Dermatitis
- ❑ ❑Eczema
- ❑ ❑Rash
- ❑ ❑Other:

_____

Allergy/Sensitivity:
- ❑ ❑Environmental:

_____
- ❑ ❑Medication:

_____
- ❑ ❑Other:

_____

Autoimmune:
- ❑ ❑Rheumatoid Arthritis
- ❑ ❑Lupus
- ❑ ❑HIV/AIDS
- ❑ ❑Other:

_____

Office Procedures

Appointment Reminders: I agree and give permission to the facility to contact me in the forms that I provided in order to remind me of future appointments both here in the office and office's that we refer to if needed.

Referrals: I agree and give permission to the facility to use my information to send "Thank You" and "Welcome" cards as well as post your first or last name in the office or on social media in reference to the patients that I send to the office.

Authorization for Information Release: I agree and give permission to the facility to disclose the information I provided to your insurance company, lawyers, third party insurance company or the credit bureau as needed. This disclosure will be made if we need their assistance to receive reimbursement for your services. You are also giving them authorization to re-disclose your information to the party responsible for the payment of your services, the association's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Assignment of Benefits: For patients **with medical insurance**, we cannot guarantee that your insurance carrier will cover your entire visit, or that your visit will apply to your in network benefits. We will, however, make every effort to ensure that your claim is paid at the best rate for you. After verification of benefits, if your annual deductible has been met, we will be glad to accept the co-insurance portion for services rendered. For your convenience, our staff will be glad to file all of your primary and secondary insurance claims: however, ***financial responsibility is ultimately the patient's***.

I authorize my insurance benefits to be paid directly to Dr. Hijazi and understand that I am financially responsible for any balance left.

Financial Arrangements: We have an open front desk and all of our financial arrangements are discussed at the front counter. If you feel you need a more private place to discuss your financial arrangement please let us know. ***Payment is required at the time of service unless arrangements have been made.***

Privacy Policy: I have been provided with (if requested) and read the practice Privacy Policy. The Privacy Notice will be available to you in the future per your request.

X-Ray permission: ***Females only:*** check one

❑This is to certify that to the best of my knowledge, I AM NOT pregnant and that Back to Wellness Chiropractic has my permission to take x-rays.

Date of last period:_____

❑I am pregnant and refuse X-Rays.

❑I could be pregnant and feel it safest to decline X-rays until test confirms or denies.

Printed Name: _____ Date:_____

Signature: _____