PID | Patient Name | DOB | Date

VanDeWalle Chiropractic Case History: Patient Information

Legal Name:_____ DOB: _____SS#:_____

Cell:_____Home:_____Work:_____

E-mail:_____

Contact Preference: Cell ( ) H ( ) W ( ) Email ( ) Appointment Reminders: Email ( ) Text ( ) Phone ( )

Address:_____

City:_____State:_____Zip:_____ Drivers Lic. #:_____

How were you referred to our office?_____

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Marital: M S W D Spouse Name: _____

Occupation: _____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Emergency Contact_____Phone:_____

Address:_____

Family Medical Doctor:_____Phone:_____

Address:_____

We may share your medical information with your physician; if you object please check here ( )

Please check any and all insurance coverage that may be applicable in this case**:**

( ) Major Medical ( ) Medicare ( ) Auto Accident ( ) MSA/ 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 VanDeWalle Chiropractic. I understand and agree to allow this office to use my patient health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I also know that as a patient I have the right to be informed about HIPAA (Health Insurance Portability and Accountability Act) by reading the HIPAA notice located at this office. 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 rendered will be immediately due and payable.

Patient Signature:_____ Date: _____

Guardian Authorization: _____ Date: _____

Witness:_____ Date: _____

PLEASE TURN OVER

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HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Other_____

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

If yes, describe:_____

What medications or drugs are you take? (Please attach more sheets if necessary) _____

_____

_____

Do you have any allergies of any kind and /or to medications? ( ) Yes ( ) No

If yes, describe:_____

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

_____

Women: Are you pregnant? _____ Date of LMP: _____

Have you had or do you now have any of the following symptoms/conditions?

Dizziness	( )	Arthritis	( )	Digestive Disorders	( )	Backaches	( )
Headaches	( )	TMJ Disorder	( )	Difficulty Sleeping	( )	Heart Trouble	( )
Diabetes	( )	Numbness	( )	Sinus Trouble	( )	Asthma	( )
Anemia	( )	Hernia	( )	Neuritis	( )	Disc Injury	( )
Cancer	( )	Nervousness	( )	Tingling	( )	Weakness	( )

FAMILY HISTORY: Please indicate if any of your family has experienced the conditions below:

Cancer	( )	Diabetes Type I/II	( )	Cardiovascular Disease	( )
Stroke	( )	High Blood Pressure	( )	Backaches	( )
MS	( )	Autoimmune Disease	( )	Other: _____	( )

SOCIAL HISTORY: Please indicate beside each activity whether you engage in it: OFTEN= “O” SOMETIMES= “S” NEVER= “N”

Vigorous Exercise	( )	High Stress Activity	( )	Family Pressures	( )	Moderate Exercise	( )
Financial Pressures	( )	Alcohol Use	( )	Other Mental Stresses	( )	Drug Use	( )
Caffeine	( )	Tobacco Use	( )	Other:_____	( )		

Patient Signature:_____ Date: _____

Guardian Authorization: _____ Date: _____

Witness:_____ Date: _____