

Chiropractic Case History/Patient Information

Date: _____

Patient #: _____

Doctor: _____

Name: _____ SS#: _____ Home #: _____

Address: _____ City: _____ State: _____ Zip _____

e-mail: _____ Fax#: _____ Cell #: _____

Age: _____ Date of Birth: _____ Race: _____ Marital M S D W

Occupation: _____ Employer: _____

Employer's Address: _____ Office #: _____

Spouse's Name: _____ Occupation: _____ Employer: _____ DOB: _____

Names/Ages of Children: _____

Emergency Contact Person: _____ Phone # _____

Family Medical Doctor: _____

May we have permission to update your medical doctor regarding your care at this office? _____

Purpose of appointment? (Chief Complaint) _____

Dates symptoms appeared or accident happened: _____

Is this due to: Auto: _____ Work: _____ Other: _____

Have you ever had the same or a similar condition? _____

Have you seen any other doctors for this condition? _____

Is the condition due to injury arising out of employment? _____ auto accident? _____

Days lost from work? _____ Date of last physical examination: _____

Have you ever been diagnosed as having or have suffered from?

(Place a check mark by conditions that apply to you.)

_____ Broken or Fractured Bones	_____ Osteoarthritis	_____ Eating Disorder
_____ Circulatory Problems	_____ Epilepsy	_____ Alcoholism
_____ Rheumatoid Arthritis	_____ Pace Maker	_____ Drug Addiction
_____ Seizures/Convulsions	_____ Strokes	_____ HIV Positive
_____ A Congenital Disease	_____ Cancer	_____ Gall Bladder
_____ Excessive Bleeding	_____ Ruptures	_____ Depression
_____ High/Low Blood Pressure	_____ Coughing Blood	_____ Ulcers

Do you have any history of stroke or hypertension? _____

Patient History Continued

Patient's Name: _____

Measles: _____ Mumps: _____ Chicken Pox: _____ Other: _____

Unusual Childhood Disease: _____

Adult Illnesses or Conditions: _____

Surgeries/Hospitalizations: _____

Fractures: _____

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 conditions by a physician in the last year? Yes / No

If yes, please describe: _____

What medicines or drugs are you taking? _____

Do you have any allergies to any medications? Yes / No

If yes, please describe: _____

Do you drink alcoholic beverages? _____ If yes, how much per week? _____

Do you use tobacco products? _____ If yes, what form/how often? _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day? _____

Do you exercise? _____ If yes: frequency/type? _____

What are your hobbies? _____

What amount of time during the day (at home or at your job) do you spend:

lifting: _____ sitti: _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now, P if you have had these conditions previously, or O if you have theme conditions occasionally.

N=Now

<input type="checkbox"/>	headaches
<input type="checkbox"/>	stiff neck
<input type="checkbox"/>	nervousness
<input type="checkbox"/>	chest pains
<input type="checkbox"/>	fatigue
<input type="checkbox"/>	ears ring
<input type="checkbox"/>	loss of balance
<input type="checkbox"/>	loss of smell
<input type="checkbox"/>	feet cold
<input type="checkbox"/>	arthritis
<input type="checkbox"/>	muscle spasms
<input type="checkbox"/>	diabetes
<input type="checkbox"/>	buzzing in ears

P=Previously

<input type="checkbox"/>	neck pain
<input type="checkbox"/>	sleeping problems
<input type="checkbox"/>	tension
<input type="checkbox"/>	dizziness
<input type="checkbox"/>	lights bother eyes
<input type="checkbox"/>	breathing problems
<input type="checkbox"/>	fainting
<input type="checkbox"/>	loss of taste
<input type="checkbox"/>	hands cold
<input type="checkbox"/>	unusual bowel patterns
<input type="checkbox"/>	frequent colds
<input type="checkbox"/>	fever
<input type="checkbox"/>	depression

O=Occasionally

<input type="checkbox"/>	loss of balance
<input type="checkbox"/>	back pain
<input type="checkbox"/>	irritability
<input type="checkbox"/>	shoulder/neck/arm/pain
<input type="checkbox"/>	numbness in fingers
<input type="checkbox"/>	numbness in toes
<input type="checkbox"/>	high blood pressure
<input type="checkbox"/>	difficulty urinating
<input type="checkbox"/>	weakness in extremities
<input type="checkbox"/>	sinus problems
<input type="checkbox"/>	indigestion problems
<input type="checkbox"/>	joint pain/swelling
<input type="checkbox"/>	menstrual difficulties
<input type="checkbox"/>	weight loss/gain

Family History

Patient's Name: _____

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 the relatives that live near you, as some hereditary conditions are affected by similar climates.

Conditions:	Father	Mother	Spouse	Child	Child	Child	Sibling	Sibling	Sibling
	age:	age:	age:	age:	age:	age:	age:	age:	age:
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list there age at death and cause:

The information on this patient information form is correct to the best of my knowledge.

Patient's Signature: _____ Date: _____

Insurance/Payment

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

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Co. (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the In Line Spine Chiropractic. 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 In Line Spine 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 your 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Office Use Only

- 1
- 4-5
- >5

Patient #: _____

Pain Drawing

Name: _____ Date: _____

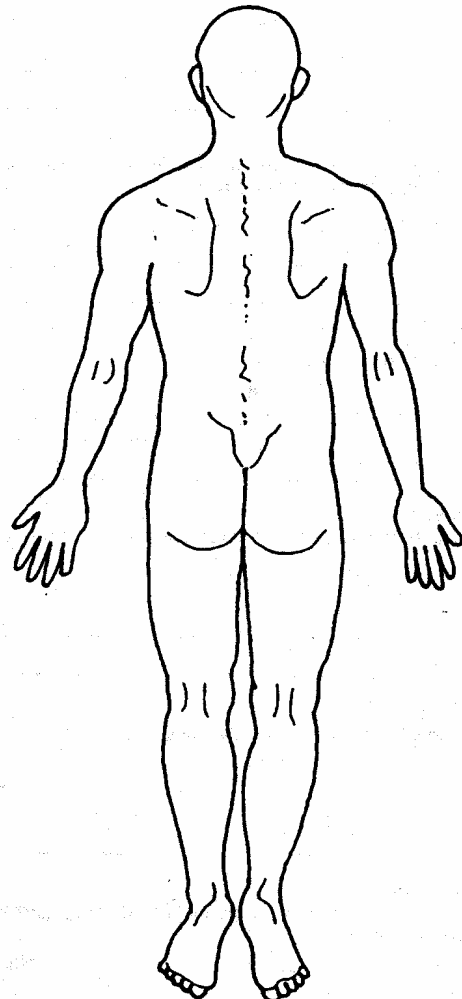
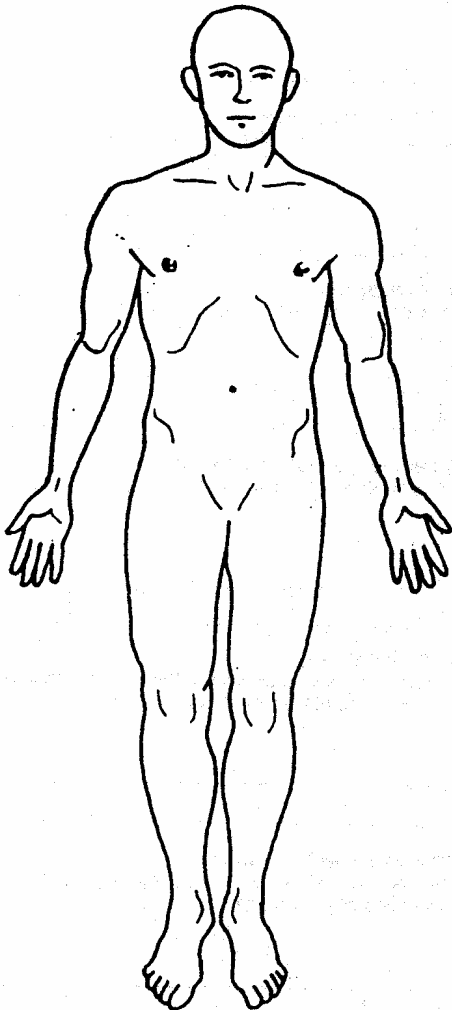
Date of Birth: _____ Examiner: Dr. Diedrich

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>> Numbness ===== Pins & Needles o o o o
Burning x x x x Stabbing // // // // Throbbing ~ ~ ~ ~ ~



Informed Consent for Chiropractic Care

A patient, in coming to In Line Spine Chiropractic, gives the doctor, Jason Diedrich, permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The chiropractic Physician provides a specialized, non-duplicating health care service. Dr. Diedrich is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at In Line Spine Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: _____ Date: _____

PREGNANCY WAIVER

I hereby acknowledge that Dr. Diedrich of In Line Spine Chiropractic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Printed Name of Patient

Signature of Patient/Authorized Representative of PatientWitness

Date

Name of Patient _____ Date _____

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully.

Sign the bottom of the sheet to indicate that you understand the instructions and information given.

- 1.If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.
- 2.If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20-minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.
- 3.Do not use heat except under the doctor's instruction. Heat may aggravate your injury.
- 4.Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.
- 5.Unless indicated by the doctor, you may return to work/school after your appointment.
- 6.If a sudden movement causes sharp or severe pain, or if you experience swelling, contact In Line Spine Chiropractic at (317) 578-0340 even if it is after office hours.

I have read and understand the instructions given for my follow-up care.

Patient's Signature

Date