# Masterson Chiropractic Case History/Patient Information

**Date:**_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

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

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

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

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

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Masterson Chiropractic Clinic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers 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 Masterson Chiropractic Clinic 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:_____

PATIENT NAME _____

DATE _____ Doctor_____

## HISTORY OF PRESENT AND PAST ILLNESS:

***Chief Complaint/biggest problem/pain*:** Purpose of this appointment: _____

_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

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

If yes, describe:_____

What medications or drugs are you taking?_____

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Any vitamins, herbs, etc.?_____

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

If yes, describe:_____

Do you have any allergies of any kind? π Yes π No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

**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 | _____ | Anxiety | _____ |
| Neck Pain | _____ | Depression | _____ |
| Stiff Neck | _____ | Schizophrenia/psychosis | _____ |
| Dizziness/Balance | _____ | Eating Disorder | _____ |
| Low Back Pain | _____ | Drug/Alcohol Addiction | _____ |
| Sciatica | _____ | Arthritis | _____ |
| Middle Back Pain | _____ | Rheumatoid Arthritis | _____ |
| Upper Back Pain | _____ | Fibromyalgia | _____ |
| Chest Pains/Tightness | _____ | Muscle Spasms | _____ |
| Shoulder/Neck/Arm Pain | _____ | Osteoporosis/Osteopenia | _____ |
| Numbness in Arms/Fingers | _____ | Joint Pain/swelling: | _____ |
| Numbness in Toes/Legs | _____ | Sinus Problems | _____ |
| Weakness in Arms/Legs | _____ | Breathing Problems | _____ |

PATIENT NAME _____

DATE _____ Doctor_____

| | | | |
|---|---|---|---|
| High Blood Pressure | _____ | Allergies/Breathing | _____ |
| Low Blood Pressure | _____ | Asthma | _____ |
| Fatigue | _____ | Fainting | _____ |
| Loss of Memory | _____ | Dizziness/Balance | _____ |
| Ears Ring/Buzz | _____ | Broken Bones | _____ |
| Diabetes | _____ | Easy Bruising | _____ |
| Seizures/Epilepsy | _____ | Pacemaker | _____ |
| Dementia/Alzhiemer's | _____ | Heart Disease | _____ |
| Stroke/TIA | _____ | Cancer | _____ |
| Aneurysm | _____ | Weight Gain/loss | _____ |
| Gall Bladder Problems | _____ | Fever | _____ |
| Bowel problem | _____ | HIV Positive | _____ |
| Liver problems | _____ | Tuberculosis | _____ |
| Ulcers/GERD | _____ | | |

**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

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor_____

**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 [ ] |
|---|---|---|---|---|---|---|
| Arthritis | | | | | | |
| Asthma-Hay Fever | | | | | | |
| Back Trouble | | | | | | |
| Bursitis | | | | | | |
| Cancer | | | | | | |
| Constipation | | | | | | |
| Diabetes | | | | | | |
| Disc Problem | | | | | | |
| Emphysema | | | | | | |
| Epilepsy | | | | | | |
| Headaches | | | | | | |
| Heart Trouble | | | | | | |
| HighBlood 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 their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

# Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)