Masterson Chiropractic Case History/Patient Information

Date: ________________ Patient #__________ **Doctor:** _________________

Name: ________________________________ Social Security # _____________________

Home Phone: (if applicable) ____________________

Address: ____ City: _______________________

State: ______ Zip code: ___________ - ________

E-mail: ____

Cellphone Carrier________________ Cell Phone Number:____________________________

Age: _______ DOB: ___________ Marital Status: M S W D

Race: (optional) ____________________

Occupation: ____________________ Employer: _____________________________________

Employer's Address: __________________________ Office Phone: ____________________

Spouse: ___________________Occupation: _______________

Employer: ____

How many children? ___________

Names and Ages of Children: ____

____

____

Emergency Contact: ____

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? ___Yes ___No

Please check **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 Primary Insurance Policy Holder _________________________DOB______________
Name of Secondary Insurance Company (if any): ____________________________________
Name of Secondary Insurance Policy Holder _______________________DOB_____________

PATIENT NAME ____DATE _____________________
Doctor: ___________________________

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 (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information (PHI) 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 (PHI) 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:

Name:	**Relationship:**	**Phone Number:**
Name:	**Relationship:**	**Phone Number:**

Patient's Signature: ____ Date: ________________

If patient is a minor:

Parent/Legal 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? __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: ____

Please list all medications that you are currently taking:

____

____

____

____

____

____

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

If yes, Please list:

____

____

____

Any vitamins, herbs, etc.? ____

____

____

____

Do you have any allergies of any kind? __Yes __No

IF yes, Please list:

____

____

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

____
____

Women: Are you pregnant? ___Yes ___No

PATIENT NAME ____

DATE ____________________ **Doctor**__________________________

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	____________
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/Alzheimer'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	__________ Family Pressures
___________ Moderate Exercise	__________ Financial Pressures
___________ Alcohol Use	__________ Other Mental Stresses
___________ Drug Use	__________ Other (please list)
___________ High Stress Activity	______________________________
___________ Tobacco Use	______________________________
___________ Caffeine	_______________________________

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/ Legal Guardian (circle one)